STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. Building B. Wing	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Lakota	608 4th Ave SW Lakota, ND 58344

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 45873 Based on record review, review of facility policy, and staff interview, the facility failed to notify the resident's physician of a change in condition for 1 of 1 sampled resident (Resident #137) with missed blood tests. Failure to notify the physician of unsucessful blood draws may have prevented the physician from altering the treatment/care provided to the resident. Findings include: Review of the facility policy titled Notification of change occurred on 06/19/24. This policy, reviewed 12/04/23, stated, . A facility must immediately inform the resident, consult with the resident's physician, and notify, consistent with her or her authority, the resident representative(s) when there is . A need to alter treatment significantly - a need to discontinue or change an existing form of treatment or to commence a new form of treatment. Review of Resident #137's medical record occurred on all days of survey. Diagnoses included chronic kidney disease. The physician's orders included a BMP [basic metabolic panel blood test] for 06/11/24 and 06/18/24. A hospital discharge summary , 05/27/24, stated, . Monitor labs and electrolytes, frequently has Hypokalemia [low potassium]. A Progress note, dated 06/11/24 at 5:37 p.m., stated, Lab draw this morning was unsuccessful, several staff attempted. Unable to find vein in upper extremities. The medical record lacked documentation the facility notified the provider regarding the missed BMPs on 06/11/24 and 06/18/24. During an interview on 06/19/24 12:55 p.m., an administrative nurse (#2) confirmed staff were unable to obtain blood samples on June 11th and 18th for the ordered lab work due to inability to find a vein. The administrative nurse stated the facility would notify the provider on next rounds.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 28611 Based on record review and staff interview, the facility failed to provide the State Long Term Care Ombudsman a notice of transfer for 1 of 1 sampled resident (Resident #9) reviewed for hospital transfers. Failure to provide a copy of the transfer notice does not allow the ombudsman to be aware of facility practices regarding transfer and discharge or advocate on the resident's behalf. Findings include: Review of Resident #9's medical record occurred on all days of survey and identified hospital transfers on 01/21/24, 02/17/24, and 03/03/24. The resident's medical record lacked evidence the facility provided a copy of the transfer notices to the ombudsman. During an interview on the afternoon of 06/19/24, an administrative staff member (#5) confirmed the facility failed to send the notices to the ombudsman prior to 06/19/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28611 Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 12 sampled residents (Resident #2 and #9). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2023, page A-32, stated, . A1500 . Code 1, yes: if PASRR [Preadmission Screening and Resident Review] Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. Page K-6 of the RAI manual stated, . K0300 Weight Loss . Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician. Section A: - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included schizoaffective disorder, bipolar type; generalized anxiety disorder; and personality disorder. A PASRR Level II Outcome, dated 12/06/23, stated, . You fall in the category of having a diagnosis that the PASRR program was designed to assess. That diagnosis is: A mental health condition. Resident #9's annual MDS, dated [DATE], identified a no response under Section A1500, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? During an interview on the afternoon of 06/18/24, a social services staff member (#1) confirmed facility staff coded Section A1500 incorrectly. Section K:-Review of Resident #2's medical record occurred on all days of survey. A significant change MDS, dated [DATE], identified weight loss; however, record review failed to identify Resident #2 experienced a 5% or more weight loss in 30 days or a 10% or more weight loss in 180 days. - Review of Resident #9's medical record occurred on all days of survey. A quarterly MDS, dated [DATE], identified weight loss; however, record review failed to identify Resident #9 experienced a 5% or more weight loss in 30 days or a 10% or more weight loss in 180 days.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28611 1. Based on observation, record review, review of facility policy, and staff and resident interview, the facility failed to provide care and services to maintain the resident's highest level of well-being for 1 of 1 sampled resident (Resident #30) with a change in health status followed by a transfer to the hospital. Failure to monitor and assess the resident's condition on an on-going basis resulted in worsening respiratory symptoms, a delay in treatment, and an admission to the hospital. Findings include:Review of the facility policy titled Notification of Change occurred on 06/19/24. This policy, dated 12/04/23, stated, . A facility must immediately inform the resident, consult with the resident's physician . when there is: . A significant change in the resident's physical, mental or psychosocial status . A need to alter treatment significantly . Observation on 06/17/24 at 11:12 a.m. showed Resident #30 ambulating in her room with oxygen in place via nasal cannula. The resident stated she was good, except I can't breathe. The resident was noticeably short of breath and sat in her recliner. The surveyor asked if the resident would like a staff member to come in, and the resident stated, No, they know, and indicated the doctor would be at the facility that day. The resident identified she has been feeling more short of breath and planned to speak with the doctor about it. Resident #30 stated she has needed increased oxygen in the last five days or so, and was now receiving 3 liters per minute (lpm) of oxygen. The resident also stated she had blisters on her leg and thought they were infected. Observation on the morning of 06/18/24 showed Resident #30 in her recliner with oxygen via nasal cannula at 3 lpm. Resident #30 stated she was still experiencing shortness of breath, and the doctor did not come to see her yesterday. Resident #30 stated she was very disappointed, but was told the doctor would be at the facility today (06/18/24). Review of Resident #30's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease (COPD), pulmonary heart disease, and congestive heart failure. Current physician's orders included: *Supplemental oxygen (O2) at 2 lpm *Ventolin HFA (hydrofluoroalkane) (used to treat or prevent bronchospasms) Inhalation Aerosol Solution, 2 puffs inhale orally every 4 hours as needed for shortness of breath (SOB), wheezing. Resident #30's nurses' notes identified the following: *06/14/24 at 5:06 a.m.: . Ventolin HFA Inhalation Aerosol Solution . 2 puff inhale orally every 4 hours as needed for SOB, wheezing. coughing with moist cough, inspiratory wheeze . *06/14/24 5:23 a.m.: . Ventolin HFA Inhalation . PRN [as needed] Administration was: Effective . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*06/14/24 at 8:15 p.m.: . Entering resident's room and noted a dry hacky cough. She states that she has increased pain to the right mid back. With ascultation [sic] [listening to lung sounds with a stethoscope], noted moderately loud rhonchi [coarse, loud sounds caused by constricted airways] to all lobes on the right and the left was clear. Vitals taken and WNL [within normal limits]. noted that there are 5 intact fluid filled blisters to her RLL [right lower leg] and the left is more red. This was noted when taking off her thigh high ted hose. There was weeping fluid from an opened blister. Xeroform [a wound dressing] place [sic] and covered with gauze and kling [a type of gauze] until provider could be notified. Do [sic] review her weights and noted a 2.5# weight gain in a week and a 9# weight gain over the past month. Did request her ventalin [sic] inhaler to help her with her coughing and feeling winded. 02 is on a [sic] 2L/NC and sats are 96%. Wull [sic] continue to monitor and report to the oncoming shift to notify provider. The record lacked evidence of physician notification. *06/15/24 at 4:19 p.m.: . Ventolin HFA Inhalation Aerosol Solution . 2 puff inhale orally every 4 hours as needed for SOB, wheezing. CN [charge nurse] notified . The record lacked evidence of a respiratory assessment or vital signs. *06/15/24 at 5:40 p.m.: . Resident did not go to dining room for her supper because she stated she wasn't feeling well. She has rhonchi in right upper and lower lobes. SOB with any exertion. left lower leg has erythema [redness] 10 x 9 cm [centimeters]. Has oxygen at 3 LPM NC due to increased SOB. Resting in recliner with legs elevated . *06/15/24 at 8:54 p.m.: . Ventolin HFA Inhalation Aerosol Solution . PRN Administration was: Effective no longer wheezing . *06/15/24 at 9:20 p.m.: . LATE ENTRY . States her cough is better tonight. Lung sounds are notably clearer with only a few rhonchi heard. Still turns 02 up to 3 liters with any activity and states this helps. *06/16/24 at 7:20 a.m.: . Ventolin HFA Inhalation Aerosol Solution . 2 puff inhale orally every 4 hours as needed for SOB, wheezing. Per CN . The record lacked evidence of a respiratory assessment or vital signs. *06/16/24 at 8:58 a.m.: . Ventolin HFA Inhalation Aerosol Solution . PRN Administration was: Effective . *06/16/24 at 3:32 p.m.: . Right lower leg with 3 large fluid filled blisters and dark red around. Left leg is lighter red with no open areas. She has expiratory wheezes thoughout [sic] all posterior lung fields and left upper lobe. Also has rhonchi to left lower lobe anteriorly. Has had trays today in room. She is short of breath at rest. [Provider name] said she will see Resident tomorrow . *06/16/24 at 8:42 p.m.: . Ventolin HFA Inhalation Aerosol Solution . 2 puff inhale orally every 4 hours as needed for SOB, wheezing. The record lacked evidence of a respiratory assessment or vital signs. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*06/17/24 at 12:00 a.m.: . Wraps applied at HS [bedtime] tonight after dressing change because they measure bigger than the day shift. Still has a harsh cough but the ventalin [sic] helps her breath [sic]. 02 is on at 3L/nc [nasal cannula] because she feels she breathes better on this. Lung sound still have rhonchi and an audible wheeze noted with activity. Provider will be seeing her this afternoon she states . *06/17/24 at 12:09 a.m.: . Ventolin HFA Inhalation Aerosol Solution . PRN Administration was: Effective less coughing . *06/17/24 at 4:34 p.m.: . received order for Mucinex [used to loosen mucus in the airways and clear congestion] 600mg [milligrams] BID [twice a day] x 1 week. Will see resident at facility tomorrow. *06/17/24 at 9:48 p.m.: . Ventolin HFA Inhalation Aerosol Solution . 2 puff inhale orally every 4 hours as needed for SOB, wheezing. The record lacked evidence of a respiratory assessment or vital signs. *06/17/24 at 10:51 p.m.: . Ventolin HFA Inhalation Aerosol Solution . PRN Administration was: Effective . *06/18/24 at 3:28 p.m.: . late entry for 0930 today. This Resident was having difficulty breathing and had wheezes throughout all lung fields. Her lower legs and feet has [sic] 4 PE [pitting edema] and bright red. I asked her if she wanted to go to the hospital and she said yes that she did. (11 [sic, 911] was called and the [NAME] Ambulance was called and they arrived at 10:00 am and transported Resident to [hospital name] . *06/18/24 at 3:55 p.m.: . called [hospital name] and Resident was admitted to the hospital. The medication administration record (MAR) identified Resident #30 received five doses of PRN Ventolin from 06/14/24 to 06/17/24, and had not used the Ventolin prior to this during the month of June. The medical record and interview with Resident #30 identified increasing respiratory distress, pitting edema, lower leg blisters, weight gain, need for continuous oxygen at 3 lpm (versus 2 lpm as ordered), and use of PRN inhalers. The facility failed to report and act on Resident #30's complaints of respiratory distress and increased oxygen needs in a timely manner, assess and monitor the resident's respiratory status on an ongoing basis, and notify the medical provider until the afternoon of 06/16/24. These failures resulted in a delay in treatment and subsequent hospital admission. During an interview on the afternoon of 06/19/24, an administrative nurse (#2) stated staff should complete an assessment when they notice a change in condition. 45873 2. Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure staff provided care and services for 2 of 12 sampled residents (Resident #1 and #16) care planned for a positioning device and physician orders for devices for pain/swelling to an arm. Failure to apply a positioning device and to follow physician's orders for devices to control edema (swelling)/pain may result in poor posture, increased pain, worsening of edema, and other complications. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Findings include: Review of the facility policy titled Positioning occurred on 06/19/24, This policy, dated 02/28/24, stated, . Purpose: To provide proper body alignment for residents in wheelchairs. Position . Resident is upright positioning and weight-bearing equally at hips (does not lean to one side). - Review of Resident #1's medical record occurred on all days of survey and included a diagnosis of dementia and osteoporosis. The current care plan stated, . The resident is at risk for falls R/T [related to] cognition deficit E/B [evidenced by] history of falls. Interventions: . Resident is to use an Evolution chair/Broda chair [reclining wheelchair]. Does tend to slide down in chair, at times. Monitor for sliding in chair at all times. Monitor resident for significant changes in mobility, positioning device, sitting balance and lower extremity joint function. Observations showed Resident #1 in a Broda wheelchair, with her body and head leaning to the left, and no positioning device present at the following times: *06/17/24 in the dining room at 12:02 p.m. in the TV room at 12:31 p.m. and in the dining room at 5:15 p.m. *06/18/24 in the TV room at 9:40 a.m. and 1:30 p.m. When asked if the resident had anything to keep her body and head upright, a certified nurse aide (CNA) (#7) stated, No, but she should have something as she always leans to that [left] side. *06/18/24 at 2:00 p.m. The CNA (#7) assisted Resident #1 to the toilet and laid her on the bed stating, she needs to lay down so she's not leaning. She is tired. *06/18/24 in the TV room at 3:20 p.m., asleep and with her body and head tilted to the left. The CNA (#7) stated the resident was restless and wouldn't stay in bed so she got her up again. *06/19/24 in the TV room at 8:15 a.m. During an interview on 06/19/24 at 1:10 p.m., an administrative nurse (#2) stated the positioning device in Resident #1's care plan is for an L-shaped pad that is supposed to be on the resident's left side in the wheelchair. The administrative nurse agreed the positioning pad should have been in the resident's wheelchair. The facility failed to assess Resident #1's positioning needs. - Review of Resident #16's medical record occurred on all days of survey. A physician's order dated 05/14/24 stated, Apply geri-sleeve [a compression device for edema/swelling and geri-sling [strapped sling] to left arm for swelling. Apply in the morning and remove at hs [hour of sleep] . for swelling to left arm. The care plan stated, . Apply geri-sleeve and geri-sling to left arm for swelling. Apply in the morning and remove at hs . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 63, stated, . Carrying Out a Physician's Order . Nurses are expected to analyze procedures and medications ordered by the physician or primary care provider. It is the nurse ' s responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber. Clarification from any other source is unacceptable and regarded as a departure from competent nursing practice. Observations of Resident #16 occurred on all days of survey and showed edema to the left hand and no geri-sleeve or geri-sling present. During an interview on 06/18/24 at 4:00 p.m., a nurse (#2) stated she assisted Resident #16 that morning and forgot to apply the geri-sleeve and sling. She also stated the sleeve and sling are for swelling and he had quite a bit when they got the order. The facility failed to follow the physician's order to apply Resident' #16's geri-sleeve and sling daily.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 28611 Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide treatment and services to aid in the healing of pressure ulcers for 1 of 3 sampled residents (Resident #31) with current pressure ulcers. Failure to provide wound treatments as ordered may result in delayed healing or deterioration of a pressure ulcer. Findings include: Review of the facility policy titled Physician/Practitioner Orders occurred on 06/19/24. This policy, dated 04/01/24, stated, . Wounds: Orders must be obtained for wound care including product to be used, when to change and when to reassess. An order is required to discontinue a current order. Review of Resident #31's medical record occurred on all days of survey. Diagnoses included a healing stage IV pressure ulcer to the coccyx. Current physician's orders stated, Cleanse wound with wound cleanser, pat dry, apply collagen powder to wound bed, lightly pack wound with calcium alginate, cover with 2x2 non bordered foam, and cover with a bordered 4x4 foam. Apply skin protectant to macerated wound edges and to surrounding skin every day shift for wound care. Observation on 06/18/24 at 2:38 p.m. showed a nurse (#10) donned gloves and a gown and removed a dressing from Resident #31's coccyx. The nurse cleansed the wound with saline spray, applied collagen powder, and covered the wound with a 4 x4 bordered dressing. The nurse failed to apply calcium alginate, a 2 x2 nonbordered foam, and skin protectant. During an interview on the afternoon of 06/19/24, an administrative nurse (#2) identified the wound was healing.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28611 Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure appropriate gastrostomy tube (G-tube) care and services for 2 of 3 sampled residents (Resident #27 and #31) with a G-tube. Failure to communicate the dietician's recommendations related to tube feedings and label the tube feeding set with identifying information may result in undesired weight gain and complications related to tube feedings. Findings include: Review of the facility policy titled Tube (Enteral) Feeding occurred on 06/19/24. This policy, dated February 2024, stated, . Tube (Enteral) Feeding Systems: . Open Enteral system - An enteral system in which the person preparing the formula is required to [NAME] formula into the entera container or bag. System Type - Open or gravity feeding: Change feeding administration set daily. Label the formula container, syringe and administration set with resident's name, date, time and nurse's initials. - Review of Resident #27's medical record occurred on all days of survey. The current care plan showed, . The resident requires tube feeding . E/B [evidenced by] swallowing problem and order for NPO [nothing by mouth] status. Resident #27's physician's orders identified, Tube feeding Osmolite [nutritional supplement] 1.2 Cal [calories]: Give 1.5 [one and a half] bottles QID [four times a day]. Observation on 06/17/24 at 10:49 a.m. showed Resident #27 in bed with the head of the bed elevated and an empty tube feeding bag connected to the resident with formula still visible in the tubing. The gravity feeding bag lacked a label to identify the type of formula, date, time, or initials. During an interview on 06/19/24 at 1:10 p.m., an administrative nurse (#2) stated her expectation is staff label all tube feeding bags with, at minimum, the date and time. - Review of Resident #31's medical record occurred on all days of survey. Diagnoses included gastrostomy tube, and dysphagia. Current physician's orders included Peptamin [sic] [an enteral feeding solution] 1.5 continuous tube feeding at 60 ml/hr [milliliters per hour] from 2100-0500 [9:00 p.m. until 5:00 a.m.] . Monitor weights and notify provider if weight loss greater than 3 pounds. A dietician's note, dated 06/04/24 at 1:21 p.m., stated, . Wt [weight]: 144# [pounds], up another 8# this month despite decrease in TF [tube feeding]. Intake is 76-100% at meals. Due to the continued weight gain, will D/C [discontinue] Peptamin [sic] feeding at night. Continue current water flushes. Expect weight to stabilize, but notify RD [registered dietician] if significant weight loss occurs. Observations on 06/18/24 and 06/19/24 showed G-tube feeding bags and a pump in Resident #31's room at 9:29 a.m. Staff members stated Resident #31 receives a tube feeding during the night but also eats meals by mouth. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #31's medication administration record identified staff continued to administer Resident #31's tube feeding after the dietician's recommendation on 06/04/24. During an interview on the afternoon of 06/19/24, an administrative nurse (#2) confirmed the facility failed to discontinue the feeding as recommended.

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	355104	A. Building B. Wing	06/19/2024

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Good Samaritan Society - Lakota	608 4th Ave SW Lakota, ND 58344

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 28611 Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide respiratory care in accordance with professional standards and the resident's plan of care for 2 of 4 sampled residents (Resident #2 and #30) and one supplement resident (Resident #15) with oxygen therapy. Failure to follow physician's orders related to the flow of oxygen and change tubing regularly may result in complications related to oxygen use. Findings include:Review of the facility policy titled Oxygen Administration, Safety, Mask Types occurred on 06/19/24. This policy, dated 06/30/23, stated, . Oxygen administration is carried out only with a medical provider order. Disposable equipment should be changed weekly or according to manufacturer's instructions and marked with date and initials. - Review of Resident #2's medical record occurred on all days of survey. Current physician's orders included, Oxygen via nasal cannula 1 liter per minute [lpm] as needed for dyspnea [shortness of breath], hypoxia (O2 [oxygen] saturation less than 88%) or acute angina [chest pain]. Call provider/practitioner with nursing report as needed for dyspnea, hypoxia, acute angina, and O2 NC [nasal cannula] keep Sats [oxygen saturations] above 90 [percent]. Observations on all days of survey showed Resident #2 continuously wore oxygen via nasal cannula at 2 lpm. Observations also showed Resident #2's portable oxygen tubing undated, and the tubing on the resident's room concentrator dated 05/16/24. The resident's medication administration record (MAR) lacked evidence of oxygen tubing changes. - Review of Resident #15's medical record occurred on all days of survey. Current physician's orders included, Continuous oxygen therapy: 3L [liters]/NC at rest, 5L/NC with activity. Observations throughout the survey (both at rest and with activity [i.e., therapy]) showed Resident #15 wore oxygen via nasal cannula at 2 lpm. Observations showed undated tubing on both the portable and in room oxygen tubing. The resident's MAR lacked evidence of oxygen tubing changes. - Review of Resident #30's medical record occurred on all days of survey. Current physician's orders included, 02 orders.-- No oxygen at rest, 1Liter continuous with exertion at bedtime, and Supplemental O2 at 2L. Pulmonology will reassess at next visit. Observations on 06/17/24 and the morning of 06/18/24 showed Resident #30 wore oxygen continuously via nasal cannula at 3 lpm. The resident stated lately she has needed more oxygen and has been wearing it at all times. Observations also showed the resident's oxygen tubing undated. The resident's MAR lacked evidence of oxygen tubing changes. During an interview on the afternoon of 06/19/24, an administrative nurse (#2) stated she would get the residents' oxygen orders clarified, and she expected staff to change oxygen tubing weekly.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46477 Based on observation, review of facility policy, review of narcotic record counts, and staff interview, the facility failed to recognize a tampered controlled medication container/packaging for 1 of 1 resident (Resident #27). Failure to physically examine the medication container/packaging for tampering in a timely manner increases the potential for medication error, loss, and diversion. Review of the facility policy titled Medications: Controlled occurred on 06/18/24. This policy, dated June 2023, stated, . The on-coming nurse will physically examine the containers/packages of each controlled medication for evidence of tampering (open packages, taped packaging, medications that look different than others .). Observations on 06/18/24 at 1:41 p.m. with a medication aide (#4) showed 16 tablets of Hydrocodone/acetaminophen, an opioid pain medication available for Resident #27. Closer examination showed one of the 16 tablets labeled G13, different than the others, and taped into the container. During this observation an administrative nurse (#2) identified the tablet as Gabapentin, a non-opioid pain medication and confirmed someone had tampered with the card.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46477 Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 1 of 14 residents (Resident #136) and one supplemental resident (Resident #7) observed during medication administration. Two medication errors occurred during staff administration of 25 medications, resulting in an 8% error rate. Failure to properly administer medications may result in residents receiving an ineffective dose and experiencing adverse reactions. Findings include: Review of the facility policy titled Medication: Documentation occurred on 06/18/24. This policy, dated September 2023, stated, .appropriate precautionary measures will accompany administration of certain medications and will be documented according to physician orders. Review of Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice, 11th ed., Pearson Education, Inc., New Jersey, page 65, stated, Make sure the correct medications are given in the correct dose, by the right route, at the scheduled time, and to the right client. Review of Resident #136's medical record occurred on 06/17/24. A physician's order identified the medication Ipratropium-Albuterol Inhalation 1 application inhale orally every 4 hours . Document oxygen saturation, pulse, respirations, and lung sounds pre [before] & post [after] administration and record the total time (min.) [minutes] nursing spent with resident on treatment. - Observation on 06/17/24 at 3:31 p.m. showed a medication aide (MA) (#3) prepared and administered an Ipratropium-Albuterol Inhalation (nebulizer treatment) for Resident #136. A licensed nurse failed to complete a pre and post assessment and failed to document vital signs and the total minutes spent with the resident. During an interview on the afternoon of 06/18/24, administrative nurse (#2) confirmed facility staff are expected to follow physician's orders as written. -Review of Mosby's 2023 Nursing Drug Reference Administer Drugs Safely, Accurately, and Professionally, 36th ed., Elsevier, Inc., Missouri, page 1046, stated, . Do not break, crush, or chew ext [NAME] [extended release] tabs . dissolve effervescent [tablet designed to dissolve in water] tabs . in 8 oz cold water or juice . Review of Resident #7's medical record occurred on 06/18/24. A physician's order identified a swallow evaluation completed. Medications included Potassium Chloride ER [extended release] daily. The medical record lacked instructions on how to administer this medication. - Observation on 06/18/24 at 8:14 a.m. showed a MA (#4) crushed and administered Potassium Chloride tablet in pudding to Resident #7. The MA (#4) failed to administer the medication dissolved in water/juice. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on the afternoon of 06/18/24, an administrative staff member (#2) confirmed the MA administered the tablet incorrectly and confirmed the orders lacked details on how to administer the medication.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46477 Based on observation, review of facility policy, and staff interview, the facility failed to prepare, store, and serve food in a sanitary manner in 1 of 1 main kitchen and 1 of 1 resident nutrition center. Failure to label food with date/time, to discard expired food, clean soiled equipment, and use outdated test strips all have the potential to affect food quality/preparation, improper sanitation, and may result in the spread of foodborne illness to residents, staff, and visitors. Findings include: Review of the facility policy titled Date Marking - Food and Nutrition occurred on [DATE]. This policy, dated [DATE], stated, . PROCEDURE . 2. When TCS [time, temperature control for safety] food has been opened but remains in storage, employees: a. Ensure ready-to-eat TCS foods opened at the locations are clearly date-marked for: 1. The date/time the original container is opened. 2. The date or day by which the food shall be consumed on the premises, sold, or discarded. 4. A food item is discarded when: c. The container or package does not bear a date or day. d. The TCS item is beyond the use by date. Review of the facility policy titled Safe Handling of Personal Food, Outside Food - Food and Nutrition occurred on [DATE]. This policy, dated [DATE], stated, POLICY: Location ensures safe and sanitary storage, handling and consumption of foods brought to the resident by family or other visitors for personal consumption. Personal food is stored separate from the location's food. Employees remove foods deemed unsafe for consumption . PERSONAL FOOD STORED IN COMMON AREAS: . Employees monitor common food storage areas . remove unsafe foods. *Observation of the main kitchen occurred on [DATE] at 10:30 a.m. with a nutrition services director (#11). Observations showed the following: Walk-in Cooler: - Individual servings of mandarin oranges (whole & puree) uncovered and undated sitting on a three-tiered cart. - One large container of blended shredded cheese not in the original container and lacked an open date/time. - One gallon of lemon lime juice (half full) lacked an open date/time. - One gallon of fat free Italian dressing (half full) lacked an open date/time. - One large container of picante sauce (half full) lacked an open date/time - One container of discolored cut up broccoli covered in saran wrap dated [DATE]. Walk-in Freezer: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Packages of meatballs and sausage links (in an unsealed bag), and not in original containers lacked the date/time the original packages were received and lacked an open date/time. - One large bag of breaded chicken breasts with visible ice crystals in an unsealed package in the original opened box. The chicken lack lacked an open date/time. - Observation showed a section of pipe covered with a large chunk of ice that dripped water onto an unopened box of food below it. The box showed water damage and had ice accumulated on top of it. Ice/Water Dispenser: - Ice and water dispenser panel and drip/drainage pan covered in of buildup of mineralization and debris. Chemical Test Strips: - Test strips used to test cleanser solution expired on [DATE]. - Chlorine test strips used to test the chlorine level for the dishwasher expired on [DATE]. *Observation of the resident nutrition center refrigerator/freezer occurred on [DATE] at 3:50 p.m. and showed the following: Resident Nutrition Center Refrigerator contained cheddar cheese dip lacked an open date/time. Resident Nutrition Center Freezer: - An open box of pizza rolls with original bag twisted closed. The box/bag lacked an open date/time. - Carmel delight ice cream (half full) lacked an open date/time. - Neapolitan ice cream (half full) lacked an open date/time. - Six ice packs. - Several packages of lemon mouth swabs. During an interview on [DATE] at 3:34 p.m., the nutrition services director (#11) confirmed the open food items lacked an open date/time and stated, I expect staff to follow policy and procedures. During an interview on [DATE] at 4:00 p.m., an administrative staff member (#2) stated, these [ice packs] should not be mixed with food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45873 Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 2 of 3 sampled residents (Resident #27 and #31) observed with enhanced barrier precautions (EBP). Failure to practice infection control standards by ensuring staff use the proper personal protective equipment (PPE) has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Standard and Transmission-Based Precautions, All Service Lines occurred on 06/19/24. This policy, revised 04/02/24, stated, . Purpose . To prevent the spread of infection . Enhanced Barrier Precautions . Enhanced barrier precautions expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs [multi drug resistant organisms] . Enhanced barrier precautions are needed for . Residents with Indwelling Medical devices (. indwelling urinary catheters . feeding tubes .) . - Review of Resident #27's medical record occurred on all days of survey. Current physician's orders included tube feeding [four times a day]. Observation on 06/17/24 at 11:05 a.m. showed a sign on Resident #27's door stating, Enhanced Barrier Precautions. A nurse (#9) without donning a gown or gloves, added water to Resident #27's tube feeding bag, flushed the line, and disconnected the tube feeding. The nurse failed to wear the appropriate PPE. During an interview on 06/19/24 at 1:10 p.m., an administrative nurse (#2) confirmed staff are to wear PPE for tube feedings. 28611 - Observation on 06/18/24 at 9:29 a.m. showed a sign on Resident #31's door identifying enhanced barrier precautions. A therapy staff member (#8) entered the room and without gowning or gloving, assisted Resident #31 to sit in an upright position and pivot to the edge of the bed for therapy exercises. During an interview on the afternoon of 06/19/24, an administrative nurse (#2) confirmed therapy staff should wear gowns and gloves while working in enhanced barrier precautions.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 46477 Based on observation, review of the North Dakota Plumbing Code, and staff interview, the facility failed to provide an air gap for 1 of 1 food-preparation sink (main kitchen) observed. Failure to provide the required air gap for a food-preparation sink has the potential to allow contamination of the sink in the event of sewer back up and bacterial migration. Findings include: Review of the 2018 North Dakota Plumbing Code, Section 801.2 Air Gap, or Air Break Required, stated, Indirect waste piping shall discharge into the building drainage system through an air gap or air break as set forth in this code. Where a drainage air gap is required by this code, the minimum vertical distance as measured from the lowest point of the indirect waste pipe or the fixture outlet to the flood-level rim of the receptor shall be not less than 1 inch (25.4 mm). Section 801.3.3 Food-Handling Fixtures, stated, Food-preparation sinks, steam kettles, potato peelers, ice cream dipper wells, and similar equipment shall be indirectly connected to the drainage system by means of an air gap. Bins, sinks, and other equipment having drainage connections and used for the storage of unpackaged ice used for human ingestion or used in direct contact with ready-to-eat food, shall be indirectly connected to the drainage system by means of an air gap. Each indirect waste pipe from food-handling fixtures or equipment shall be separately piped to the indirect waste receptor and shall not combine with other indirect waste pipes. The piping from the equipment to the receptor shall be not less than the drain on the unit and in no case less than 1/2 of an inch (15 mm). Observation on 06/17/24 at 10:30 a.m., showed a continuous drainage pipe passed into the wall with no visible air gap for the main kitchen food-preparation sink. During an interview on the afternoon of 06/17/24, an environmental services director (#12) lacked an air gap.