STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Miller Pointe A Prospera CO	3500 21st St SE Mandan, ND 58554

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 19410 Based on review of the facility reported incident, review of facility policy, and record review, the facility failed to report an incident of potential neglect to the State Survey Agency (SA) for 1 of 1 sampled resident (Resident #1) who fell out of a mechanical lift. Failure to report an event of potential neglect in the required time frame does not comply with regulations established to protect residents. Findings include: Review of the facility policy, Abuse and Neglect, occurred on 09/19/24. This policy, dated 07/22/24, stated, PURPOSE: * To ensure that employees are knowledgeable regarding the reporting and investigative process of abuse and neglect allegations in the location .* To ensure that all identified incidents of alleged or suspected abuse/neglect . are promptly reported and investigated. PROCEDURE: . 4. Notification procedures: a. Alleged or suspected violations involving any mistreatment, neglect . will be reported immediately to the administrator. b. In case of absence of the administrator, follow the chain of command for notification (director of nursing services, social worker, etc.). Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency. ii. If there is an allegation that does not involve abuse and there is no serious bodily injury, then it will be reported not later than 24 hours after the allegation is made. Review of the facility reported incident, received by the SA on 09/13/24, indicated Resident #1 fell from a full body lift on 09/11/24. Review of the final investigation report, dated 09/17/24, stated, [name of resident] fell in his room witnessed while being transferred in a total lift by 2 staff. Staff did not loop sling on lower left side and hook to lift appropriately. Assessment completed and nurse noted right knee was swollen and indent noted. Review of the facility reported incident identified the facility reported Resident #1's fall out of a mechanical lift on 09/13/24, two days after the incident occurred. Facility staff failed to report an incident of potential neglect within the required timeline of 24 hours. Refer to F689.

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

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 19410 Based on record review, policy review, review of staff education, review of facility reported incident, and resident interview, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 of 1 sampled resident (Resident #1) who fell out of a mechanical lift. Failure to safely use the mechanical lift resulted in a fall with injury for Resident #1. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following the incident. Findings include: The surveyor determined a deficient practice existed on 09/11/24. The facility immediately implemented corrective action and completed corrective action on 09/16/24. Review of the facility policy, Safe Resident Handling Program Overview occurred on 09/17/24. This policy, dated 02/28/24, stated, . Policy: . goal is to maintain a safe living . environment for residents . All caregivers . must receive thorough, documented training prior to conducting mobilization . Care givers will perform a TIME OUT safety stop while the resident is in a sling or harness and still over the surface of the bed or chair to ensure that all straps are secure before moving away from the surface. This is to be competed once the straps are taut, but before the resident leaves a surface. Review of final investigation of the facility reported incident, dated 09/17/24, stated, [name of resident] fell in his room witnessed while being transferred in a total lift by 2 staff. Staff did not loop sling on lower left side and hook to lift appropriately. Assessment completed and nurse noted right knee was swollen and indent noted. Resident was immediately seen by floor nurse post fall and assessment completed. Resident alert and orientated post fall. No concerns of abuse or neglect noted. Staff members that were involved with transfer were immediately interviewed and education provided. Competency completed by registered nurse on 2 staff post incident. Administration reviewed all staff meeting competency and education reviewed at that time. Discussed lift education with those due for annual education. Resident did not have any concerns and did not want to be seen by a provider until his primary was due to round 9/13/2024. On provider visit she discussed getting an Xray and he finally agreed. Preliminary showed fractures of right tibia and fibula. Results of Investigation: Resident was transferred with total lift by 2 staff. One staff member did not loop sling bottom appropriately which resulted in resident falling out of lift. Resident had seen orthopedics and has immobilizer . Final Action Taken: No indication of abuse or neglect. Staff education completed and competency done with 2 staff involved incident immediately. During an interview with Resident #1 on 09/17/24 at 9:00 a.m. regarding the fall from the mechanical lift, the resident stated, it was just an accident, one strap wasn't hooked up right. The resident stated his leg bent behind him, but he didn't have any pain because of his paraplegia. Resident #1 stated he didn't go to the emergency room (ER) right after it happened because there wasn't anything they could do about it anyway. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's medical record occurred on the morning of 09/17/24. The record identified Resident #1 as cognitively intact and able to make decisions. Review of nursing progress notes identified the following: * 09/11/24 at 12:49 p.m., This nurse was called to residents' room. Resident was on the ground with one strap attached to the Hoyer lift and the left strap was not attached. CNA [certified nursing aide] stated that the strap was not looped into the other strap on the left side. Resident uses a multipurpose sling. Resident was being transferred from his w/c [wheelchair] back into his bed. Resident stated his leg got bent back when he fell to the floor. Residents right knee was slightly swollen and had a small indent on it under the knee. Resident did not bump his head. Resident denied any pain. Resident is a paraplegic. This nurse did ROM [range of motion] on residents left knee. Resident was Hoyer [mechanical lift device] lifted back to bed and vitals were took which were WDL's [within normal limits] for resident. This nurse assessed resident and found no bruising on resident. This nurse had therapy assess residents' knee while back in bed. A note was left for provider and resident will be seen on Friday as resident would like to see [name of provider] PA-C [Physician's Assistant - Certified]. This nurse called residents wife and explained thoroughly everything noted. * 09/12/24 at 3:55 p.m., Fall team met to discuss recent fall, education has been completed including competency with staff present during fall, all staff competency and education reviewed and discussed with those due for annual education. * 09/13/24 at 5:43 p.m., . Resident returned from his x-ray. Resident has 2 fractures in his right knee and was sent to ER. Resident denied surgery and has a splint on his right knee. Resident is suppose [sic] to see ortho in a week but at this time is going to think on it since he is being discharged next week. Resident had no other new orders noted. Residents' wife is aware of all the new orders listed and resident's wife was at ER with resident. Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented corrective actions as follows: * The employees involved in the incident were immediately re-educated on Safe Resident Handling and use of the mechanical lift and slings. * Provider and family notified of the fall and follow up care and treatment provided. * Education provided to all staff members on Safe Resident Handling, including use of various lift devices, types and sizes of slings, and mechanical lift scenarios.