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	12/31/2025

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 5 of 19 sampled residents (Resident #3, #37, #65, #73, and #121) observed during cares. Failure to practice infection control standards related to enhanced barrier precautions (EBP), personal protective equipment (PPE), dressing changes, glove changes, and hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Hand Hygiene occurred on 12/30/25. This policy, revised 11/13/25, stated, . all employees . will adhere to the 4 Moments of Hand Hygiene . 1. Entering room [ROOM NUMBER]. Before a clean task 3. After bodily fluid/glove removal 4. Exiting room. PROCEDURE: HCW [healthcare worker] will use waterless alcohol-based hand sanitizer or soap and water to clean their hands: When entering the resident room . After removing gloves regardless of the task completed . After contact with a patient's non-intact skin, wound dressings, secretions, excretions . When moving from contaminated body site to a clean body site during patient care .Review of facility policy titled Standard, Enhanced Barrier, and Transmission-Based Precautions occurred on 12/30/25. This policy, revised 07/07/25, stated, . Enhanced barrier precautions expand the use of personal protective equipment 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 . Enhanced barrier precautions are also used for residents with chronic wounds . residents with indwelling medical devices . High contact resident care activities include transfers, indwelling medical device care or use . wound care. Post clear signage indicating the type of precautions and required PPE . -Observation on 12/29/25 at 11:26 a.m. showed an EBP sign and a container of PPE supplies outside Resident #73's room. A nurse (#7) applied a gown, gloves, and mask and entered the room. The nurse removed the soiled dressing from Resident #73's left leg wound and, with the same gloves reached into a basket containing clean dressings and scissors, cut a new dressing and applied the dressing to the wound. The nurse then removed the PPE and left the room to obtain gauze. When nurse (#7) returned, he/she placed the gauze package on the PPE stand, applied PPE, picked up the gauze package, and entered the room. The nurse readjusted Resident #73's wound dressing, obtained a scissors from the supply basket, cut the gauze, secured the dressing, and returned the scissors to the basket. The nurse (#7) removed the PPE and without performing hand hygiene, exited the room. The nurse (#7) failed to perform hand hygiene before applying gloves, failed to remove the soiled gloves, perform hand hygiene, and apply clean gloves after removing the soiled dressing, and failed to perform hand hygiene before exiting Resident #73's room. -Observation on 12/29/25 at 11:32 a.m. showed Resident #37 in bed. The certified nurse aide (CNA) (#12) completed hand hygiene, gloved, and gathered supplies for morning cares. The CNA completed (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bowel incontinence care and without performing hand hygiene or applying clean gloves, completed perineal cares. With the same soiled gloves, the CNA applied a clean brief and the transfer sling under the resident, and finished cleaning the resident. The CNA connected the sling to the mechanical lift, reached into the uniform pocket, called for assistance on the handheld walkie, and then removed the soiled gloves and applied clean gloves. Another CNA (#13) entered the room, assisted the CNA (#12) to transfer Resident #37 to the wheelchair, performed hand hygiene, and exited the room. The CNA (#12) finished dressing the resident, rinsed the dentures and glasses, and handed them back to the resident. The CNA (#12) straightened the bed and room, bagged the soiled linens and garbage, removed one glove, completed hand hygiene on one hand, and exited the room with the bagged soiled linen and garbage in the gloved hand. The CNA (#12) failed to complete glove changes/hand hygiene between tasks. -Observation on 12/29/25 at 1:33 p.m. showed an EBP sign and a container of PPE supplies outside Resident #3's room . Two CNAs (#1 and #2) applied gowns, gloves and face masks and entered the room. The CNAs transferred Resident #3 from the wheelchair to the bed with a full body mechanical lift. The CNA (#1) emptied the urine from foley catheter collection bag. The CNAs removed their PPE, and exited the room. Both CNAs (#1 and #2) failed to perform hand hygiene. -Observation on 12/30/25 at 7:34 a.m. showed an EBP sign and a container of PPE supplies outside Resident #65's room. The CNA (#3) applied PPE and entered the room, transferred the resident from the recliner to the wheelchair, applied the foot pedals to the wheelchair, removed the PPE, and exited the room. The CNA (#3) failed to perform hand hygiene. -Review of Resident #121 medical record occurred on all days of survey. A physician's order, dated 12/24/25, indicated a foley catheter. Observation on 12/30/25 at 8:23 a.m. showed PPE supplies outside Resident #121's room and no EBP sign. Two CNAs (#9 and #10) entered the room, completed hand hygiene, applied gloves, and transferred Resident #121 from the wheelchair to the bed with gait belt assistance. Both CNAs removed their gloves, completed hand hygiene, and exited the room. The facility failed to place proper signage for EBP and the CNAs (#9 and #10) failed to apply gowns. Observation on 12/30/25 at 9:51 a.m. showed an EBP sign and a container of PPE supplies outside Resident #121's room. The CNA (#11) entered the room, completed hand hygiene, gloved, and emptied the urine collection bag. The CNA failed to apply a gown. During an interview on 12/31/25 at 12:25 p.m., two administrative staff members (#6 and #8) acknowledged the infection control issues and stated staff should follow policy and procedures.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for medication administration for 1 of 1 sampled resident (Resident #100) observed with medications at bedside. Failure to ensure residents take all prescribed medications and document medication administration may result in errors and/or adverse effects for the resident.Findings include: Review of the facility policy titled Medication: Administration Including Scheduling and Medication Aides occurred on 12/30/25. This policy, dated 04/08/25, stated, . Do not leave medications at the bedside or at the table unless there is a specific physician order to do so . if the resident has not been assessed for safety . and there is not a physician order to leave the medication . stay with the resident until the medication is taken and you observed the resident swallow. Review of Resident #100's medical record occurred on all days of survey. A physician's order, dated 10/17/24, stated, please make sure resident is taking medications with each med pass. Observation on 12/29/25 at 10:57 a.m. showed a medication cup containing several pills on Resident #100's bedside table. Review of the Medication Administration Record (MAR) for 12/29/25 identified facility staff administered Resident #100's scheduled morning medications. During an interview on the afternoon of 12/30/25, an administrative nurse (#6), stated she expected staff to ensure Resident #100 consumed all the medications prior to leaving the room and the resident is not appropriate to self-administer medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, review of facility policy, and staff interview, the facility failed to ensure safe and secure medication storage for 1 of 6 unlocked and unattended medications cars (Driftwood Lane). Failure to securely store medications may result in unauthorized access to medications by residents, visitors, and staff. Findings include: Review of the facility policy titled Medications: Storage occurred on 12/31/25. This policy, dated 03/04/25, stated, Policy Statement . Medication Storage. medications will be stored in a locked medication cart, drawer, or cupboard . are locked when not in use, . carts used to transport such items are not left unattended if open or otherwise available to others . Observation on 12/29/25 at 5:55 p.m. showed a nurse (#7) walked away from the medication cart on Driftwood Lane and entered a resident room. The nurse (#7) left the medication cart unlocked/unattended and the electronic medical record (Emar) left open with resident information visible to staff, residents, and visitors. Observation showed two insulin pens and a clear bucket containing insulin pens on top of the medication cart. During an interview on 12/31/25 at 1:20 p.m., an administrative nurse (#6) stated she expected staff to lock medication carts and the Emar and store all medications in the cart.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review, review of menus, review of facility policy, and staff interview, the facility failed to serve food according to prepared menus for 3 of 3 sampled residents (Resident #10, #11, and #74) observed during tray line. Failure to serve food according to the portion sizes listed on the resident's menu/tray card may result in inadequate nutrition and weight loss or weight gain.Findings include: Review of the facility policy titled Portion Control . occurred on 12/31/25. This policy, revised 01/28/25, stated, . To ensure that the menu items are served in the planned quantity . The portion sizes listed on the menu extensions or tray cards are followed. Portion sizes are referenced during meal service. Observation of the noon tray line on 12/30/25 showed a dietary staff member (#5) served the following: *Resident #10, one-third cup (c) of pureed stuffed pepper soup and one-third c of mashed sweet potato. The menu identified the serving sizes as one-half c soup and one-half c sweet potatoes. The tray card identified two-thirds c of soup, which didn't match the menu. *Resident #11, a #6 scoop (5.5 ounce [oz] or 2/3 c) of stuffed pepper soup and one-half of a baked sweet potato. The tray card and menu identified a six-ounce ladle of soup and one whole sweet potato. *Resident #74, a #6 scoop (5.5 oz or 2/3 c) of stuffed pepper soup and one-half of a baked sweet potato. The tray card and menu identified a six-ounce ladle of soup and one whole sweet potato. - Review of Resident #10's medical record occurred on all days of survey. The care plan stated, Nutrition: The resident has nutritional problem R/T [related to] underweight and triggering for at risk of malnutrition E/B [evidenced by] low BMI [body mass index] . and hx [history] of weight loss. The dietary staff member (#5) failed to serve Resident #10, #11, and #74 the correct portion size of soup and sweet potatoes, resulting in the residents receiving less food than the menu identified. During an interview on 12/31/25 at 11:20 a.m., a dietary manager (#4) stated she expected staff to follow the ladle or scoop sizes listed on the tray cards.