STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355104	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Lakota	**608 4TH AVE SW , LAKOTA, North Dakota, 58344**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a facility reported incident and a complaint was completed on June 16, 2026. During the complaint investigation the facility was found non-compliant with regulatory requirements.	F0000		06/24/2026
F0725 SS = E	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of	F0725	F0725 Sufficient Nursing Staff 1. For those residents found to have been affected by the deficient practice For Resident A- long wait for call light response and staff assistance causing the resident to be incontinent- The facility cannot go back to respond timely to call light and staff assistance. For Resident B – long wait time for call light response and staff assistance causing the resident to be incontinent- The facility cannot go back to respond timely to call light and staff assistance For Resident C- voiced concerns of long wait time for call light response and shutting call light off without helping the resident -The facility cannot go back to respond timely to call light and staff assistance For Resident D-waited long time for staff assistance, at 11:15 resident decided no point in getting up for lunch and chose meal tray instead. The facility cannot go back to respond timely to call light and staff assistance 2. For all other residents identified as having the potential to be affected by the same deficient practice- All residents have the potential to be affected by this deficient practice. 3. What Measures and Systemic changes made to ensure the deficient practice will not recur Education was provided to nursing staff by DNS or designee on GSS policy and procedure specific to call light response and timely staff assistance during shift-to-shift huddles, and 1:1s starting 6.25.2026. Facility Process Change: Charge nurse monitors call light monitoring system and response time to ensure timely call light response throughout the shift. Leader rounding process implemented to assist with answering call lights and checking in with residents	07/10/2026

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 reverse for further 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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F0725 SS = E	Continued from page 1 duty. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of facility policy, confidential resident interviews, and staff interviews, the facility failed to ensure sufficient nursing staff to meet resident needs for four confidential residents (Residents A, B, C, and D) who required staff assistance. Failure to provide sufficient staffing and answer call lights in a timely manner does not promote a resident's right to physical, mental, and psychosocial well-being. Findings include: Review of the facility policy titled call lights occurred on 06/16/26. This policy, dated July 2025, stated, ". . . Purpose. To ensure residents always have a method of calling for assistance. To promptly answer resident's call light. . . . When resident's call light is observed/heard go to resident's room promptly. Respond to request as soon as possible. . . . ." Confidential resident interviews and observations on 06/16/26 identified the following: *At 8:57 a.m., observation showed Resident A's call light on. At 9:09 a.m., an unidentified staff member turned the call light off while picking up meal trays. The staff member told the resident she would be back to help her. At 9:16 a.m., Resident A stated, "I have my call light on, and staff should be coming in to help me to the bathroom", and "Call light wait time is worse in the morning because they are getting everyone up. They are short on staff here." The resident also stated, "There have been a few times I have been incontinent but most of us wear diapers here." At 9:28 a.m., an unidentified therapy staff member brought Resident B (Resident A's roommate) into the room. At 9:29 a.m., Resident B turned the call light on. At 9:31 a.m., a certified nurse aide (CNA) (#4) entered the room and asked who needed help. Resident A stated, "We both do, but I have been waiting longer." The CNA exited the room and returned with the stand lift. Resident A waited 34 minutes for assistance. *At 12:57 a.m., observation showed resident B's call light on. During an interview, Resident B stated, "The longest wait time is thirty minutes or so." An administrative staff member (#7) then entered the room and asked what they needed (Resident A and Resident B). Both residents stated they needed to	F0725	Continued from page 1 to ensure needs are met. 4. How the facility plans to monitor its performance to make sure the solutions are sustained Administrator or Designee will conduct random audits on residents to ensure their needs are met and timely call light response. Audits will be completed weekly x 4 weeks, monthly x 2 months and quarterly x 1 quarter. Audit findings will be submitted to the QAPI Committee for review and further recommendations to ensure compliance. 5. Completion of the plan of correction July 10,2026	07/10/2026

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F0725 SS = E	Continued from page 2 use the restroom. Resident B stated, “The big man came in about ten minutes ago [approximately 12:47 p.m.] and was going to find someone to help.” The administrative staff member then left the room. Resident B stated “It is too late for me already. It was me that shit my pants this time, last time it was her [Resident A].” At 1:06 p.m., (approximately 19 minutes after the "big guy" came into the room) a CNA (#4) entered the room to assist the residents. *At 1:48 p.m. Resident C stated, “I sometimes have to wait a long time for help. The longest I have had to wait for help was four hours. Sometimes certain CNAs and staff members enter my room and turn off my call light off without helping me.” *At 2:23 p.m. Resident D stated, “My roommates bath took a little longer than expected this morning, so my CNA was not able to get me up. At 11:15 [a.m.] I figured there was no point to get up for lunch and I chose to eat lunch in my room. Call light wait times depend upon what’s going on. If they are short it takes a while to get help, the longest was maybe forty-five minutes or so.” During interviews at 4:33 p.m. and 6:00 p.m., an administrative staff member (#2) stated staff are expected to get residents up at the time requested, answer call lights timely, and it is unacceptable for staff to turn off call lights to find someone else.	F0725		07/10/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An	F0657	F0657 Care Plan Timing and Revision 1. For those residents found to have been affected by the deficient practice For Resident #1- completed sit stand walk UDA on 6/25/2026, and care plan updated. For Resident # 6- he no longer resides in the facility. 2. For all other residents identified as having the potential to be affected by the same deficient practice All residents have the potential to be affected by this deficient practice. 3. What Measures and Systemic changes made to ensure the deficient practice will not recur Education was provided to nursing staff by DNS or Designee on Care Plan GSS policy and procedure specific to providing care per care plan and updating with changes during shift-to-shift huddles, and 1:1s starting 6.25.2026 Facility Process Change: Order listing report reviewed each clinical morning meeting to ensure care plans are updated with current	07/10/2026

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F0657 SS = D	Continued from page 3 explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation and record review the facility failed to review and revise care plans to reflect the resident's current status for 2 of 6 sampled residents (Residents #1 and #6). Failure to update care plans limit the staff's ability to communicate residents' needs and ensure continuity of care. Findings Include: - Review of Resident #1's medical record occurred on 06/16/26 and identified a left intertrochanter (hip) fracture. The current care plan stated, ". . . The resident has an ADL [activities of daily living] self-care performance deficit R/T [related to] elzhiemers [sic] E/B [evidenced by] need for staff to anticipate needs and wants. . . ." An intervention, revised on 02/09/26 stated, "Ambulation: X1 (one person) staff assist, using the standing lift [mechanical sit to stand lift] for all transfers . . . Resident does not ambulate. . . ." During an observation on 06/16/26 at 2:35 p.m., two certified nurse aides (CNAs) (#4 and #5) transferred Resident #1 from the wheelchair to the bed using a full body mechanical lift and not a sit to stand lift as care planned. - Review of Resident #6's medical record occurred on 06/16/26. Physician orders included, ". . . Assure Heel Boots are on at all times and heels are offloaded every shift for Pressure Ulcers to left great and 2nd toes . . . Prevalon [padded] boots to both feet on at all times . . . related to pressure ulcer of left heel." The current care plan stated, ". . . The resident has potential for impairment to skin integrity R/T central cord syndrome at C [cervical disc] 5 [five] . . . Prevalon boots to both feet while in bed . . ."	F0657	Continued from page 3 resident needs. 4. How the facility plans to monitor its performance to make sure the solutions are sustained Social Services or designee will conduct random audits on ensuring care for residents is being provided per care plan. Audits weekly x 4 weeks, monthly x 2 months and quarterly x 1 quarter. Audit findings will be submitted to the QAPI Committee for review and further recommendations to ensure compliance. 5. Completion of the plan of correction July 10, 2026	07/10/2026

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F0657 SS = D	Continued from page 4 The facility failed to update Resident #6's care plan to reflect heel boots at all times.	F0657		07/10/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and staff interviews, the facility failed to provide care and services to prevent the development of pressure ulcers for 2 of 6 sampled residents (Residents #1 and #6) with pressure ulcers. Failure to provide repositioning and utilize pressure relief devices appropriately may result in the development/worsening of pressure ulcers. Findings include: Review of the facility policy titled “Pressure Ulcers” occurred on 06/16/26. This policy, dated March 2026, stated, “. . . will use prevention and assessment interventions to ensure that a resident entering the location without pressure ulcers does not develop a pressure ulcer unless the individual’s clinical condition demonstrates that this was unavoidable. . . . A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing. . . .” Review of the facility policy titled “Positioning” occurred on 06/16/26. This policy, dated December 2024, stated, “. . . To position residents unable to	F0686	F0686 Treatment / Services to Prevent/Heal Pressure Ulcers 1. For those residents found to have been affected by the deficient practice For Resident #1-care plan was updated for repositioning and toileting. For Resident # 6-no longer resides in facility. 2. For all other residents identified as having the potential to be affected by the same deficient practice All residents have the potential to be affected by this deficient practice. 3. What Measures and Systemic changes made to ensure the deficient practice will not recur Education was provided to nursing staff by DNS or designee on Pressure Ulcer GSS policy and procedure specific to receiving services to maintain skin integrity during shift-to-shift huddles, and 1:1s starting 6.25.2026 Facility Process Change: Weekly IDT meeting to review residents with pressure ulcers are getting care to treat pressure ulcers. 4. How the facility plans to monitor its performance to make sure the solutions are sustained DNS or designee will conduct random audits on residents to ensure residents repositioned based on care plan, and toileting completed per care plan. Audits will be completed weekly x 4 weeks, monthly x 2 months and quarterly x 1 quarter. Audit findings will be submitted to the QAPI Committee for review and further recommendations to ensure compliance. 5. Completion of the plan of correction July 10, 2026.	07/10/2026

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F0686 SS = D	Continued from page 5 position/reposition independently in a manner which . . . maintains skin integrity. . . .” - Review of Resident #1's medical record occurred on 06/16/26. Physician’s orders included, “Frequent repositioning r/t [related to] Buttock skin breakdown.” The current care plan stated, “. . . The resident has bladder incontinence R/T loss of ability to identify urinary needs . . . The resident has existing pressure ulcers R/T need for staff assist will all repositioning . . . Reposition resident on a routine basis . . .” Observation on 06/16/26 at 8:45 a.m., 11:31 a.m., and 12:35 p.m., showed Resident #1 seated in a reclining wheelchair. At 2:35 p.m., two certified nurse aides (CNAs) (#4 and #5) performed a check and change. The residents brief, pants, mechanical lift sling, and pressure-relieving pad in the wheelchair were saturated with urine. The CNA (#4) stated residents are repositioned every two hours. Facility staff failed to reposition Resident #1 or provide a brief change for almost three hours. - Review of Resident #6's medical record occurred on 06/16/26. Diagnoses include a spinal cord injury and diabetes mellitus. Physician orders included, “Assure Foot cradle is on bed and bed blankets are draped over it and the foot board every shift. Assure Heel Boots are on at all times and heels are offloaded. Pressure ulcers to left great and 2nd toes . . . Prevalon [padded] boots to both feet . . . related to pressure ulcer of left heel.” The current care plan stated, “. . . The resident has potential for impairment to skin integrity R/T central cord syndrome at C [cervical] 5 [five] . . . inability to reposition self . . .. Reposition with each brief check and change . . . Foot cradle to foot of bed to keep blankets lifted off the feet . . .” Observations on 06/16/26 at 1:27 p.m. and 4:48 p.m. showed Resident #6 in bed positioned on their left side with blankets draped directly over the resident's feet and not over the foot cradle or foot board. A nurse's progress noted, dated 06/16/2026 at 2:17 p.m., stated, “Skin Issues Note: 2 x [by] 2 cm [centimeter] deep tissue injury to back of upper right leg Skin issue education: Change clothing / briefs.	F0686		07/10/2026

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F0686 SS = D	Continued from page 6 Skin issue education: Change / shift positions frequently. Skin issue education: Care of skin issue(s). Skin issue education: Turn every 2 hours." During an interview on 06/16/26 at 4:13 p.m., a nurse (#9) confirmed staff discovered the deep tissue injury during a skin assessment today (06/16/26). During an interview the afternoon of 06/16/26, an administrative staff member (#2) stated she expected staff to reposition residents every two hours, confirmed the facility staff failed to document repositioning, and expected the foot cradle to be used as ordered. The facility failed to ensure the blankets were over the foot cradle and not directly on Resident #6's feet as ordered. Residents #1 and #6's medical records lacked documentation of repositioning every 2 hours.	F0686		07/10/2026