STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355106	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, North Dakota, 58554**

(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 The Standard Medicare/Medicaid recertification survey started 12/29/25 and concluded 12/31/25.	F0000		01/23/2026
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F0880	F880 – Infection Control Enhanced Barrier Precautions The policy entitled “Standard, Enhanced and Transmission based Precautions” was reviewed and remains in place unchanged. Emphasis and education are placed on adhering to this procedure related to Signage and Personal Protective Equipment. All residents requiring Enhanced barrier precautions have the potential to be affected by this deficient practice. Residents’ #3, #37, & #121 had no untoward effects, and no corrective intervention is required. Residents #65 & #73 have discharged. All residents requiring Enhanced barrier precautions were checked for the proper signage on 1/16/26. Education was completed by the director of nursing or QAPI coordinator on 1/27/26 for all staff. Education will consist of review of the Standard, Enhanced and Transmission based Precautions policy. Beginning the week of 2/2/26, the QI coordinator and/or her designee will complete QI monitoring that random Enhanced Barrier precaution residents Ensuring Proper Personal Protective equipment is used as well and correct signage posted weekly X 4, then monthly X 2. Hand Hygiene The Policy entitled “Hand Hygiene” was reviewed and remains in place unchanged. Emphasis and education are placed on adhering to this procedure All Residents have the potential to be affected by this deficient practice. Residents’ #3, #37, & #121 had no untoward effects, and no corrective intervention is required. Residents #65 & #73 have discharged.	02/04/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355106	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/31/2025

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F0880 SS = E	Continued from page 1 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: 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,	F0880	Continued from page 1 Education was completed by the director of nursing or QAPI coordinator on 1/27/26 for all staff. Education will consist of review of the “Hand Hygiene” policy. Beginning the week of 2/2/26 the QI coordinator and/or her designee will complete QI monitoring of random Hand Hygiene opportunities weekly X 4, then monthly X 2 to ensure that proper infection control is maintained. Results of the QI monitoring will be reviewed as part of the monthly facility QI meetings and then summarized at the Quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results. Date Certain: 2/4/26	02/04/2026

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F0880 SS = E	Continued from page 2 stated, ". . . all employees . . . will adhere to the 4 Moments of Hand Hygiene . . . 1. Entering room 2. 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	F0880		02/04/2026

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F0880 SS = E	Continued from page 3 Resident #37 in bed. The certified nurse aide (CNA) (#12) completed hand hygiene, gloved, and gathered supplies for morning cares. The CNA completed 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	F0880		02/04/2026

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F0880 SS = E	Continued from page 4 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."	F0880		02/04/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: 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."	F0658	F-658- Services Provided Meet Professional Standards The policy entitled "Medication: Administration Including Scheduling and Medication Aides- R/S, LTC" was reviewed and remains in place unchanged. Emphasis and education is placed on adhering to this procedure. Resident #100 had no untoward effects related to this deficiency. They will be included in auditing to ensure compliance. This deficient practice has the potential to affect all residents receiving medication. Education was completed by the director of nursing or QAPI coordinator On 1/27/26 for all staff with medication administration privileges. Education will consist of review of the "Medication: Administration Including Scheduling and Medication Aides- R/S, LTC" QI monitoring will begin the week of 2/2/26 using the QI Audit tool entitled Medication Label/Storage/Standards. Audits will be completed by the QAPI coordinator and or her designee on Random medication administrations across all shifts weekly x 4, monthly x 2. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results summarized for the quarterly QAPI meeting with the Medical Director in Attendance. The need for further monitoring will be determined based upon these results. Date Certain: 2/4/26	02/04/2026

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F0658 SS = D	Continued from page 5 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.	F0658		02/04/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: 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).	F0761	F-761-Labeling of Drugs and Biologicals The policy entitled “Medications: Acquisition Receiving Dispensing and Storage- R/S, LTC” was reviewed and remains in place unchanged. Emphasis and education is placed on adhering to this procedure. This deficient practice caused no untoward effects to specific residents requiring remedy. This deficient practice has the potential to affect all residents receiving medication. Education was completed by the director of nursing or QAPI coordinator on 1/27/26 for all staff with medication administration privileges. Education will consist of review of the Medications: Acquisition Receiving Dispensing and Storage- R/S, LTC policy. QI monitoring will begin the week of using the QI Audit tool entitled Medication label/storage/standards. Audits will be completed by the QAPI coordinator and or her designee on Random medication administrations specific to locking of medications inside the cart, and closing the computer screen weekly x 4, monthly x 2. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results summarized for the quarterly QAPI meeting with the Medical Director in Attendance. The need for further monitoring will be determined based upon these results. Date Certain: 2/4/26	02/04/2026

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F0761 SS = D	Continued from page 6 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.	F0761		02/04/2026
F0803 SS = D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received	F0803	F-803- Menus meet resident needs The policy entitled Portion Control was reviewed and remains in place unchanged. Emphasis and education are placed on adhering to this procedure. Education completed with Staff #5 on duty upon knowledge of the deficient practice. Residents who were noted to be affected by the deficient practice were reviewed on 1/19/2026 to ensure current meals reflect appropriate portion sizes per approved menus including resident #10. Resident #11 and #74 no longer reside in the facility; therefore, no ongoing risk exists for those individuals. All residents have the potential to be affected, and therefore corrective measures will be implemented facility-wide. Education was completed by the Dietary Manager or QAPI coordinator on 1/27/26 for all staff. Education	02/04/2026

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F0803 SS = D	Continued from page 7 from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: 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	F0803	Continued from page 7 will consist of review of the policy entitled "Portion Control" and Reference Materials. Dietary manager verified proper serving utensils were in place for all menu items on 1/16/26. New dietary employees will receive portion control training during orientation prior to independently serving meals. QI monitoring will begin the week of 2/2/26 using the QI Audit tool entitled Portion Sizes. Audits will be completed by the Dietary Manager, QAPI coordinator and/or her designee on Random Meal services weekly x 4, monthly x 2. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results summarized for the quarterly QAPI meeting with the Medical Director in Attendance. The need for further monitoring will be determined based upon these results. Date Certain: 2/4/26	02/04/2026

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F0803 SS = D	Continued from page 8 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.	F0803		02/04/2026