STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355089	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PARK RIVER	**301 SOUTH COUNTY ROAD 12B , PARK RIVER, North Dakota, 58270**

(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 and complaint survey started on 08/18/25 and concluded 08/21/25. During the complaint investigation, the facility was found noncompliant with regulatory requirements.	F0000		09/25/2025
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 (f) 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 (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by:	F0725	Licensed nurses and CNA's working on 8/22/25 were verbally educated "it is facility requirement that all employees are to promptly answer resident call lights". All resident have the potential to be affected. Education to All Staff by the DNS and Administrator on the GSS "Call Light" policy on 9/20/25 or by compliance date. New Facility Practice: Facility leadership rounding each business day to assist in answering call lights/ interview residents on call light response concerns. Call light response concerns lifted up at resident council will be documented on GSS Concern/Suggestion form and investigated/addressed by leadership within 5 business days. Facility will continue to recruit staff and utilize agency to meet resident's needs. DNS or designee will audit call light times for extended call times and do resident satisfaction audits. Audits will be completed 1x/week for 4 weeks, then 1x/month for 2 months, then 1x/quarter for 1 quarter. Any deficient practice identified will be addressed immediately. Audit results will be submitted to QAPI Committee for review and recommendations. 9/25/25	09/25/2025

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 Based on review of facility policy, review of call light logs, and resident, family, and staff interviews, the facility failed to ensure sufficient nursing staff and related services are available at all times to meet the residents' needs for 2 of 8 sampled residents (Resident #30 and #39), one supplemental resident (Resident #26) and 1 confidential resident (Resident A) who required staff assistance. Failure to provide sufficient staffing does not promote each resident's rights, physical, mental, and psychosocial well-being, and/or provide a safe environment for the residents. Findings Include: Review of the facility policy titled "Call Light" occurred on 08/20/25. This policy, revised 07/08/25, stated, "When residents call light is observed/heard, go to the resident's room promptly. . . . Respond to request as soon as possible. . . ." Resident and family interviews occurred on the morning/afternoon of 08/18i25 and identified the following: * Resident A stated they are short of staff here, it takes 30 minutes to answer my call light. * Resident #26 stated it can take 30 minutes for staff to answer my call light. * Resident #30 reported it has been up to half an hour or more before staff answer the call light, identified having to wait on the toilet a long time, and “they forget about me." *Resident #30's family member identified concerns with call lights being answered timely on various shifts, and Resident #30 has waited up to an hour for staff to answer the call light and has had urinary incontinence due to waiting. *Resident #39 stated, it can take 45 minutes to get my call light answered and I talked to staff, and nothing changed. Review of the call light logs from 08/14/25 to 08/18/25 showed the following and call light response: * Resident #39 waited 25 minutes or greater on 7 occasions and the longest wait 50 minutes. * Resident #26 waited 25 minutes or greater on 6 occasions and the longest wait 53 minutes.	F0725		09/25/2025

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F0725 SS = E	Continued from page 2 *The call light logs from 7/17/25 to 8/18/25 showed Resident #30 waited 17 to 22 minutes or greater on 9 occasions and the longest wait 27 minutes. During an interview on the morning of 08/21/25 an administrative nurse (#1) confirmed the call light log showed staff failed to answer call lights promptly. During confidential staff interviews on 08/20/25 at 11:03 a.m., confidential staff members (B, C, D, E, F) stated the staff worked short most shifts, administration was aware, and the shortages continued in resident care areas and in the dining room with feeding assistance.	F0725		09/25/2025
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of professional reference, review of facility policy, and staff interview, the facility failed to ensure food is prepared and stored in a clean and sanitary manner in 2 of 2 kitchen/nutrition centers (main kitchen and nutrition center) observed. Failure to ensure cleanliness of the kitchen and proper food storage has the potential for contamination of food and may	F0812	Upon discovery, the main kitchen was cleaned to include floor, oven hood, cabinet doors, back splash and walls by food prep area/sink, storage drawers, silverware dividers was thrown, storage shelves, reach-in refrigeration unit, reach-in freezer and ceiling fan. The open unlabeled, undated bag of chicken cordon blue, skinless chicken breast and hushpuppies were discarded. Upon discover the gel ice pack was removed from the upright freezer. Verbal education on clean and food stored safely, and cleanliness of kitchen was given to the dietary manager on 8/22/25 by administrator. All residents have the potential to be affected. All dietary staff were educated by Administrator on 9/17/25 worked on GSS “Food Preparation – Food and Nutrition” in reference to proper food handling is used in preparing food and regular cleaning/sanitizing of equipment, utensils and work surfaces are performed during food preparation. “Food Handling – Food and Nutrition” in reference to food items are handled appropriately for food safety, including all food prepared for meals and snacks regardless of where the time is served or stored. “Date Marking – Food and Nutrition” in reference to the procedure expected to ensure ready-to-eat foods opened are clearly dated for date of container opened, and date food should be consumed on, or discarded. New Facility Practice: Dietary manager will do a weekly walk through to verify cleaning schedule and log implementation is completed. Administrator or designee will conduct observation	09/25/2025

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F0812 SS = E	Continued from page 3 result in a foodborne illness to residents, visitors, and staff. Findings include: The 2022 Food and Drug Administration (FDA) Food Code, Chapter 4, Section 4-6, pages 20-21, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, stated, ". . . (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. . . . (C) Non FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. . . ." Review of the facility policy titled "Food Preparation -Food and Nutrition" occurred on 08/19/25. This policy, dated March 2025, stated, ". . . Regular cleaning/sanitizing of equipment, utensils and work surfaces are performed during food preparation as needed . . .” Observation of the main kitchen occurred on 08/18/25 at 12:55 p.m. with dietary staff member (#8) and showed the following: * An accumulation of dirt and debris on the floor, and a large, blackened area under the three-compartment sink. * An accumulation of a sticky substance on the lip of the oven hood. * An accumulation of a sticky substance on the outside of all the cabinet doors within the kitchen. * An accumulation of food residue on the back splash and walls behind the food prep area and food prep sink. * An accumulation of debris in the utensil and other storage drawers that contain food and miscellaneous dishware. * An accumulation of a sticky yellow substance around the inside rims of a silverware divider within a utensil drawer. * Visible dried particles of red colored food on pan covers on a storage shelf. * Visible food debris on the bottom of the reach in refrigeration unit, along with a sticky dark pink	F0812	Continued from page 3 audits of kitchen for cleanliness of all areas: floor, walls, oven hood, cupboard doors, drawers, storage shelves, fridges, and freezer. Will audit food items for proper storage, labeling, and dating. Will audit refrigeration/freezer to verify non-food items are not present. Will audit completion of kitchen log. Audits will be completed 1x/week for 4 weeks, then 1x/month for 2 months, then 1x/quarter for 3 quarter. Any deficient practice identified will be addressed immediately. Audit results will be submitted to QAPI Committee for review and recommendations. 9/25/25	09/25/2025

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F0812 SS = E	Continued from page 4 substance on the sides and bottom of the unit. * The reach in freezer unit contained a large unopened bag of onion rings with layers of ice buildup within the bag. * One ceiling fan with an accumulation of dust and hanging debris in the dishwashing area. The walk-in refrigerator showed: *An accumulation of grey-green mold on the underside of the two-fan condenser unit. *An accumulation of debris on all the metal wired shelving units. The walk-in freezer showed: * One open, unlabeled, and undated bag of chicken cordon blue. * One open, unlabeled, and undated bag of skinless chicken breast. * One open, unlabeled, and undated bag of hushpuppies. *Observation of the nutrition freezer on 08/19/25 at 12:52 p.m. showed a large blue gel ice pack stored beside ice cream cups. During an interview on 08/20/25 at 11:23 a.m., a dietary staff member (#8) stated he expected staff to clean all areas of the kitchen and store food properly.	F0812		09/25/2025
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.	F0657	The care plan for Resident #28 was updated on 8/21/25 to include correct transfer status. The care plan for Resident #12 was updated on 8/21/25 to correct interventions to goals and weight loss. Verbal education provided to clinical and dietary leadership team by Administrator on 8/22/25 regarding care plan updates and notifications. All residents have the potential to be affected. Additional education will be provided by DNS to clinical leadership team and licensed nurses on the GSS “Care Plan-Rehab, Skilled” policy and procedure, specific to updating care plan to include resident’s individualized interventions to meet currents needs on 9/18/25 or prior to compliance date.	09/25/2025

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F0657 SS = D	Continued from page 5 (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 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, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plans to reflect the residents' current status for 2 of 14 sampled residents (Resident #12 and #28). Failure to update care plans limited staffs' ability to communicate needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plan" occurred on 08/20/25. This policy, revised December 2024 stated, ". . . The plan of care will be modified to reflect the care currently required/provided for the resident." -Observation on 8/18/25 at 4:00 p.m. showed a certified nurse aide (CNA) (#3) transferred Resident #28 from the wheelchair to the bathroom using a sit to stand mechanical lift. Review of Resident #28's medical record occurred on all days of survey. The care plan stated, "Pivot transfer with one assist using the gait belt for toileting. . . .Transfer: Resident requires AX1 [assist times one] staff to stand pivot transfer with gait belt." During an interview on 08/20/25 at 1:09 p.m. a staff nurse (#4) confirmed Resident #28 transferred using a sit-to-stand lift. -Review of Resident #12’s medical record occurred on all days of survey and showed a weight loss of	F0657	Continued from page 5 New Facility Process: Clinical team meeting will be held each business day. Agenda includes reviewing all residents with change of condition to include verification care plan is updated if indicated. DNS or designee will audit 5 current residents care plans for accuracy 1x/week for 4 weeks, then 1x/month for 2 months, then 1x/quarter for 3 quarters. Any deficient practice identified will be addressed immediately. Audit results will be submitted to QAPI Committee for review and recommendations. 9/25/25	09/25/2025

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F0657 SS = D	Continued from page 6 greater than 10% in one month. The care plan, stated, "The resident has unplanned/unexpected weight loss R/T [related to] (SPECIFY) E/B [evidenced by] (SPECIFY) Resident will maintain weight between (SPECIFY: _____ and _____ lbs.) by review date. Weigh (SPECIFY FREQ. [Frequency])" The care plan failed to include interventions and goals related to Resident #12's weight loss.	F0657		09/25/2025
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility to ensure residents received adequate supervision/assistance to prevent accidents for 1 of 1 sampled resident (Resident #30) observed during a sit-to-stand lift transfer. Failure to ensure proper use of a leg strap placed Resident #30 at risk for possible injury. Findings include: Review of the facility policy titled "Safe Resident Handling Equipment-Competency Validation Checklist" occurred on 08/21/25. This policy, dated December 2024, stated, ". . . Checks resident care plan or Kardex prior to transfer for type of equipment to be used, type and size of sling and amount of assistance required . . . If directed by care plan or location specific procedure, uses the shin/calf strap when the resident requires additional lower extremity support . . . Applies the shin/calf strap when the resident is in a seated position, before rising to a standing position . . . . " Review of Resident #30's medical record occurred on all days of survey. Diagnoses included muscle weakness and orthopedic pain. The current care plan stated, ". . . TRANSFER: The resident requires staff	F0689	Physical therapy assessed Resident #30 on 8/22/25, transfer status stayed the same. Resident discharged from physical therapy on 09/17/2025. All residents care planned for the use of sit-to-stand lifts have the potential to be affected. Education will be provided by the DNS and Administrator to licensed nurses and CNAs on GSS “Safe Resident Handling” policy with competency’s checklist regarding providing care as per the care plans, specific to using the sit-to-stand lift/sling use on 9/18/25 or by compliance date. New Facility Practice: Clinical team meeting will be held each business day. Agenda includes reviewing all residents with change of condition to include verification care plan is updated if indicated. DNS or designee will conduct observation audits of 4 different staff members performing sit-to-stand transfers, verifying care is provided as per care plan. Audits will be completed 1x/week for 4 weeks, then 1x/month for 2 months, then 1x/quarter for 3 quarter. Any deficient practice identified will be addressed immediately. Audit results will be submitted to QAPI Committee for review and recommendations. 9/25/25	09/25/2025

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F0689 SS = D	Continued from page 7 assist for 1 for toileting and transfers with the stand lift." The care plan failed to address the need for a shin strap. Observation on 8/19/25 at 3:58 p.m. showed a certified nurse aide (CNA) (#11) transferred Resident #30 from the wheelchair to the bathroom using the sit to stand mechanical lift. The CNA failed to attach the leg strap and place the resident's shins against the shin rests. During the transfer, the resident's legs shifted and buckled, hands failed to grip the handlebars, and his/her arms/elbows pushed outward and upward. The CNA failed to apply the leg strap during transfer and notify the nurse of the resident's unsafe transfer. During an interview on 08/21/2025 at 12:43 p.m., an administrative nurse (#5) confirmed Resident #30 transferred using a sit-to-stand lift, and she expected staff to report any resident change in transfer status.	F0689		09/25/2025
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:	F0761	On 8/20/25 licensed nurse went through 100-200 Med Cart and Medication Storage Room and discarded all expired meds. Licenses nurses on shift were verbally educated by Administrator on 8/20/25 regarding ensuring medication carts and storage rooms are audited with a tracking form on medication storage monthly. All residents have the potential to be affected that have orders for medications. Additional education to licensed nurses by the DNS and Administrator on GSS “Medications: Acquisition Receiving Dispensing and Storage” in reference to routinely check for expired medications and necessary disposal will be done in accordance with state/pharmacy regulation on 9/18/24 or prior to compliance date. New Facility Practice: Medication carts and Medication Storage Room will be checked by licensed nurse monthly utilizing med storage tracking audit form. DNS or designee will audit medication carts and storage room for expired meds and utilization of the med storage audit form. Audits will be completed 1x/week for 4 weeks, then 1x/month for 2 months, then 1x/quarter for 3 quarter. Any deficient practice identified will be addressed immediately. Audit	09/25/2025

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F0761 SS = D	Continued from page 8 Based on observation and staff interview, the facility failed to discard expired medications in 2 of 3 medication storage areas (100-200 Wing Medication Cart and Medication Storage Room) reviewed. Failure to discard expired medications may result in decreased effectiveness of the prescribed medication. Findings include: -Observations on 08/19/25 at 1:40 p.m. of the medication storage room showed the following: * Three saline solution laxatives expired in December 2024. * Two tubes of antimicrobial skin wound gels expired in November 2024. * One bottle of antiseptic liquid for skin wounds expired in March 2025. -Observation on 08/19/25 at 1:50 p.m. of the medication cart (100-200 wing) showed one bottle of nystatin powder expired December 2024. During an interview on 08/20/25 at 2:57 p.m., an administrative nurse (#1) confirmed expired medication should be discarded and not used.	F0761	Continued from page 8 results will be submitted to QAPI Committee for review and recommendations. 9/25/25	09/25/2025