STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	03/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(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
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on March 25, 2013 and completed on March 27, 2013 the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	4-18-13

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.

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GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156		

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	355113	A. BUILDING _____ B. WING _____	03/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(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
F 156	Continued From page 2 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the correct address for the North Dakota Long Term Care (LTC) Ombudsman Program for 3 of 3 days of survey (March 25-27, 2013). Failure to maintain the correct contact information limits the residents' and families' access to this agency. Findings include: Observations occurred at the following times: * March 25 at 4:00 p.m. * March 26 at 8:25 a.m. * March 27 at 8:15 a.m. The observations showed a poster for the LTC Ombudsman program which listed the incorrect address for the Bismarck office. During an interview on 03/27/13 at 9:15 a.m., an administrative staff member (#3) stated he was unaware the poster was incorrect.	F 156	F156 1. On 3/27/13, an updated poster with the correct Ombudsman contact information was placed on our bulletin board, replacing the outdated information. 2. All residents could potentially be affected through the inability to contact the Ombudsman. 3. A quarterly audit will be put in place for one year, completed by our social worker, to ensure our Ombudsman information is up to date. This audit will be reviewed at our internal monthly Quality Assurance meeting 4. A quarterly audit will be put in place for one year, completed by our social worker, to ensure our Ombudsman information is up to date. This audit will be reviewed at our internal monthly Quality Assurance meeting. 5. Corrective action will be completed by 5/1/13.	

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	355113	A. BUILDING _____ B. WING _____	03/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

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F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, record review and staff interview, the facility failed to administer medication according to professional standards of practice for 1 of 1 supplemental resident (Resident #12) receiving inhalant medication. Failure to administer an inhalant medication utilizing the proper technique of waiting 1 minute between puffs may prevent the second puff from fully penetrating the resident's lungs. Also, failure to wait five minutes before administering a second inhalant medication may result in an ineffective response to the medication. Findings include: Review of the facility policy titled "Procedure - Inhalant Medication" occurred on 03/27/13. This policy, dated January 2009, stated, "Purpose - To administer an inhalant medication in a safe manner. To aid a resident who cannot self-administer inhalant. Note: If more than one inhalant is administered at the same time, . . . wait five minutes between inhalants. . . . Procedure . . .11. If a second puff of any ordered inhalant is ordered, wait one minute between puffs. . . ." - Review of Resident #12's medical record occurred on 03/26/13. Diagnoses included	F 281	F 000 General Disclaimer Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth the facts alleged or conclusions set forth the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes that facility's allegation of compliance in accordance with section 7305 of the State Operation Manual. F281 1. The needs of resident #12 were met on 3/27/12 when a clarification physicians order was observed. The order clarified to give Atrovent inhaler 1st and Advair 2nd, it clarified to wait one minutes between puffs of inhalant medication and it clarified to wait five minutes between each inhaler. 2. Resident's receiving an inhalant medication ordered for more than one puff and/or more than one	

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	03/27/2013

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OOD SAMARITAN SOCIETY - ARTHUR	180 COUNTY RD 34 ARTHUR, ND 58006

(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
F 281	Continued From page 4 chronic airway obstruction. A physician order, dated 08/03/12, included Atrovent inhaler (a bronchodilating inhalant medication) two puffs four times a day. Another physician order, dated 01/23/13, included Advair (an inhalant medication for maintenance therapy for airflow obstruction) two puffs inhalation twice a day. On 03/26/13 at 8:15 a.m., observation showed a licensed nurse (#1) administered the Atrovent and Advair inhalers to Resident #12. Resident #12 received two puffs of each inhaler with 2-5 seconds between puffs of the individual inhalers. The nurse immediately administered the Advair inhaler after the Atrovent inhaler and failed to wait five minutes between inhaler medications. During an interview on 03/27/13 at 9:32 a.m., an administrative nursing staff member (#2) confirmed the facility's inhaler policy and the wait times required between puffs and between inhalers.	F 281	inhalant medication scheduled at the same time have the potential to be affected. 3. All physicians' orders for inhalant medications of more than one puff and/or more than one inhalant medication scheduled at the same time have been clarified to include as part of the order, wait 1 minute between puffs and/or wait five minutes between each inhalant medication. Education was provided to Licensed nurse #1 on 3/28/13 regarding Good Samaritan Society Procedure titled Inhalant Medication. A mandatory meeting will be held for nursing staff on 4/17/13. Education will be provided on the Good Samaritan Society Procedure titled Inhalant Medication. 4. Staff Development Coordinator will complete the audit Medication Administration Competency Checklist weekly for two nursing staff members for one month and monthly for one nursing staff for five months. The results of the audits will be reported to QA/CQI committee for further recommendations. 5. Corrective action will be completed by May 1, 2013	