AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED
	355113	B. WING	04/03/2014

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 April 1, 2014 and completed on April 3, 2014, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 3 additional records to verify specific concerns during the survey.	F 000	F00 General Disclaimer Preparation and execution of this response and plan of correction does not constitute and 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 requirement of participation, this response and plan of correction constitutes that facility's allegation of compliance with section 7305 of State Operation Manual.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure resident access to the most recent Health and Life Safety Code surveys including the plans of correction on 3 of 3 days of survey (April 01-03, 2014). Findings include: On all days of survey, observation showed the most recent Health and Life Safety survey results located inside of a locked cabinet in the hallway. The key hung on the wall above the cabinet, approximately six feet from floor level.	F 167	F-167 1. Survey book was removed from locked cabinet on 04-04-2014. survey book was place in bin by cabinet, with easy access to all residents, staff and visitors. 2. All residents, staff and visitors have the potential to be affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	5-9-14

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that or safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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 _____	04/03/2014

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 167	Continued From page 1 On the morning of 04/03/14, a supervisory maintenance staff (#5) agreed the location of the key would limit resident access to the cabinet, and the survey results/binder.	F 167	F-Tag 167 cont. 3. Education was provided to all staff on 4-21, 22 and,23rd 2014 at staff in-services on location of survey book and access for residents/visitors who may wish to review survey book. 4. Deficiency corrected ~~4-04-2014~~. 4/23/14 per T.C - DON dl. 5. The DON will audit the placement of survey book weekly X 1 month and then monthly x5 month to ensure it remains in the correct location. Reports will be reviewed at QA committee meetings.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain privacy for 2 of 9 sampled residents (Resident #1 and #8) and one supplemental resident (Resident #11) in a manner and environment that maintained or enhanced each resident's dignity during 2 of 2 days (April 01-02, 2014) of medication pass observations. Failure to maintain each resident's privacy during administration of medication did not maintain respect, enhance dignity or recognize the resident's individuality. Findings include: - During observation of medication pass on the morning of 04/02/14, a licensed nurse (#7) entered a resident's room for medication administration. Prior to applying a transdermal (applied to skin surface) medication patch, the nurse walked to the bathroom and opened the door without knocking. The resident's roommate, Resident #11 sat on the toilet and stated "you	F 241		

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F 241	Continued From page 2 could have knocked." The nurse then proceeded to enter the bathroom to perform hand hygiene with soap and water. - During observation of insulin administration on the evening of 04/01/14, the nurse (#8) entered Resident #1's, #8's and #11's rooms without knocking. The nurse entered Resident #1's and #8's rooms on two occasions, once to perform a blood glucose and once to administer insulin. During an interview on the afternoon of 04/02/14, an administrative nurse (#4) stated failure to knock before entering closed resident doors does not maintain resident dignity.	F 241	F-Tag 241 1. The needs of residents #1, #8 and #11 were met when education was provided to nurses #7 and #8 regarding knocking prior to enter residents rooms and bathrooms to maintain dignity and respect to all residents. Good Samaritan Policy on Dignity and Respect was reviewed with each nurse. 2. All residents have the potential to be affected . 3. All staff were educated at staff meetings held on 4-21, 22, 23rd 2014, regarding dignity and respect of residents. Good Samaritan Policy on Dignity and Respect reviewed at meetings. Residents will be surveyed regarding Dignity and Respect at monthly resident council meetings 4. Deficiency corrected on 4-23-14. 5. Director of Nurses or designee will complete a focus audit on Dignity and Respect which will include 10 random audits on Staff members weekly X 1 month and then 15 random audits monthly X 6 months All findings will be reported to QA committee for review.	
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident group interview, review of the Resident Council meeting minutes, review of the facility Activities Calendars, review of resident activities attendance logs, review of facility policy and procedure, and staff interview, the facility failed to provide an ongoing program of activities designed to meet the interests of 6 of 7 interviewable residents (Resident A, B, C, D, E, and F) who participated in a group resident interview. Failure to provide an ongoing program of weekend activities to meet the interests of the	F 248		

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F 248	Continued From page 3 residents did not meet the residents' physical, mental, and psychosocial well-being. Findings include: Review of the facility procedure, "Activity Services Calendar," occurred on 04/03/14. This procedure, revised in June 2010, stated "PURPOSE . . . To provide a variety of programs based on needs, interests and abilities of residents. . . . PROCEDURE, 1. The activity services calendar of events will be based on resident interests and abilities as well as the care plan goals and interventions. 2. Whenever possible, seek input from residents . . . when planning the monthly activity services calendar of events. . . ." A request for the Resident Council meeting minutes for the past four months occurred during the entrance conference with the facility staff, on 04/01/14 at 11:30 a.m. The Resident Council president authorized review of the meeting minutes. Review of the Resident Council meeting minutes for the months provided, October 2013 through March 2014, occurred on April 01, 2014. The meeting minutes, dated 02/10/14, stated "ACTIVITIES: . . . [activities management staff member (#10)] also talked about activities on the weekend. Some residents said there was down time but that is when their family usually comes. . . ." During the group interview, on 04/01/14 at 3:30 p.m., 6 of 7 interviewable residents attending the group interview (Resident A, B, C, D, E, and F) reported weekend activities are limited to "church and TV" and visitors. The residents reported they do not always have visitors and would like additional activities on weekends.	F 248	F-Tag 248 1. Activity calendars were revised by Activity Director to include activities resident requested during interview process. (Described in #3) 2. All residents have the potential to be affected. 3. 10 residents were interviewed by Activity Director regarding weekend activities and their preferences. Resident concerns on activities will be reviewed monthly at resident council meetings. 4. Compliance completed on 5-01- 2014. 5. Activity Director will audit weekend activities and resident participation weekly X 2 months and then monthly X 4 months to ensure residents activity needs are met. Resident concerns on activities will be reviewed monthly at Resident Council. These audits will be reviewed at QA committee meeting.	

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F 248	Continued From page 4 Review of the Activities Calendars for the months of March and April 2014 showed the following: *Saturday - exercise, Helping Hands (linen folding), Bingo, devotions, coffee, and an evening movie; *Sunday - three different religious services on television, coffee, and television in the evening. Review of the March 2014 Activities Participation Records for Resident A, B, C, D, E, and F showed the residents attended the scheduled activities and did not attend unscheduled activities. During interview, on 04/03/14 at 8:15 a.m., an activities management staff member (#10) reported the following regarding weekend activities: - occasional concerns from residents regarding limited activities - nursing staff set up movies in the evenings, if they have time - weekend activities are limited - activities has a limited staff budget and few volunteers. This staff member (#10) confirmed interviewing residents regarding their activities preferences would be an effective method to determine their needs.	F 248		
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	F 281	F-Tag 281 1. Resident # 5 will be transported to and from bath area in a wheelchair with foot supports. All nurses were informed of failure to report incident occurring with resident #5 therefore preventing an investigation for follow up measures. 2. Failure to report and investigate resident injuries may affect all residents.	

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F 281	Continued From page 5 by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to ensure services provided to residents meet professional standards of quality regarding reporting of and investigation of injuries and accidents, for 1 of 1 resident with an injury (Resident #5) not identified through the incident reporting process. Failure to report and investigate Resident #5's injury prevented the facility from determining why or how it may have occurred, and identify and implement corrective action. Failure to report and investigate resident injuries may affect all residents. Findings include: Review of the facility's procedure, "Incident Report," occurred on 04/03/14. This procedure, revised January 2011, stated "PURPOSE, To document resident and visitor incidents, To conduct an investigation of each incident, To gather objective information and identify root causes to prevent similar occurrences from happening in the future. DEFINITION, Incident - an occurrence with or without injury . . . not limited to, a physical injury . . . PROCEDURE, 1. The Incident Report . . . is completed for each resident and/or visitor incident that occurs. . . ." Review of Resident #5's medical record occurred on April 01-03, 2014. The interdisciplinary progress notes stated: *12/18/13 at 11:52 a.m., "Skin on Lt [left] 2, 3, 4 toes rubbed against the carpet with transport back to her rm [room] from tub rm. Areas at base of toenails & [and] [sic] are very superficially	F 281	F-Tag 281 cont. 3. All staff were in serviced on April 21, 22, and 23rd 2014 regarding reporting of incidents that occur in the facility, timeliness and notification of appropriate personnel was addressed. Good Samaritan Policy on Incidents reviewed at this time. All Nursing staff was instructed on completing incidents in PCC under risk management for all all resident incidents. Director of Nursing will review Risk Management report daily in a.m. in PCC to investigation the incident of each resident and identify causes to prevent further occurrences 4. Date of Compliance 4-23- 2014. 5. Director of nursing will audit All incidents that occur in the facility for completion, and ensuring all incidents are documented on an actual incident report. These audits will be completed weekly x 6 months. Incident occurence analysis will be reviewed monthly by QA/Safety	

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F 281	Continued From page 6 excoriated. Areas left open to air & shoe left off. Will monitor daily." During interview, on 04/03/14 at 9:25 a.m., a supervisory nursing staff member (#4) confirmed the facility staff failed to provide Resident #5 with foot supports during transport from the tub room. This staff member (#9) stated the completion of an incident report would ensure a thorough investigation to determine causative factors and specific corrective action.	F 281		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 1. Based on record review, policy and procedure review, and staff interview, the facility failed to assess 1 of 1 sampled resident (Resident #3) who exhibited elopement risk behaviors, implement effective interventions to prevent elopement, resulted in Resident #3 eloping from the facility without staff knowledge and crossing a well traveled street. Findings include: Review of the facility's policy titled "Elopement" occurred on 04/02/14. The policy, dated July	F 323	F-Tag 323 1. The needs of resident #3 were met when wanderguard was placed and doors secured. Care plan updated to address History of elopement on 4-29-2014. Social Service completed updated Social Service Assessment on 4-08-2014 which addresses elopement. The needs of resident # 5 were met when resident is being transferred to and from the bath area in her w/c with foot pedals. Resident's left toe areas are healed and no further incidents have occurred. 2. A review of all residents who wander and have poor safety judgement have the potential to be affected. All residents that are transferred in wheelchairs have the potential to be affected.	

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F 323	Continued From page 7 2008, stated, ". . . Elopement - When a resident who needs supervision leaves the premises or a safe area without authorization, (i.e. an order for discharge or leave of absence) and or a necessary supervision to do so. Policy: The center will be responsible for maintaining a system which clearly defines the mechanisms and procedures for monitoring and managing residents at risk for elopement. These include identifying environmental hazards and resident risks; evaluating/analyzing hazards and risks; implementing interventions; and monitoring/modifying interventions as needed. All residents will be assessed for risk of elopement through the pre-admission and/or admission process and as needed. Each center will put measures in place to minimize the risk of elopement that are individualized to resident needs and identified on the care plan. . . ." During an interview on the initial tour on the afternoon of 04/01/14, a supervisory staff member (#6) stated Resident #3 exited the facility one week prior and walked to her house, a block away, and across a street. Review of Resident #3's medical record occurred on April 1-3, 2014. Medical diagnoses included dementia, paranoid psychosis with mood disorder, seizures, and wandering behavior. The quarterly Minimum Data Set, dated 01/08/14, identified the resident with moderately impaired cognition and requiring supervision for locomotion off the unit. Review of the interdisciplinary progress notes indicated Resident #3 an elopement risk as follows: *04/06/13, 11:45 a.m. - "Resident is extremely	F 323	F-Tag 323 cont. 3. On April 21, 22, and 23rd 2014 Staff In-services was held. Education was provided to all staff on the Good Samaritan Policy on Elopement. On May 5th 2014 a mandatory Nursing meeting was held an Education was provided on assistive devices/ foot pedals needed during a safe transfer of resident. Effective May 1st 2014 All new admissions to the facility will be Screened using the Pre- admission Data Collection Form, which addresses elopement. All current residents will have a Social Service Assessment done quarterly with which reviews elopement and safety concerns. 4. Deficiency corrected on May 9 2014. 5. Director of Nursing will audit all Pre-admission Screenings on new admits to ensure adequate safety measures are placed for residents at risk x 6 months. DON will complete 6 monthly audits on resident transfers and devices used to include foot pedals, weekly x 1 month then monthly x 5 months The results of these audits will be reported to the QA committee for review.	

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F 323	Continued From page 8 upset. Face is flushed. She is shouting that she is 'marching right out of here' 'to my house where I can live as I want' When staff attempt to cue redirect distract she gets more angry. Has fists clenched, jaw set, and tells staff she is 'leaving now and I don't care what you say'" *07/20/13, 12:30 p.m. - "Resident looking out window and wants to go to 'my house, right there' pointing out a south window. Is angry when told she cannot go unassisted and needs family to take her there." *09/22/13, 3:00 p.m. - "Res [resident] out at NS [nurses' station] getting increasingly agitated because she cannot go outside. Following various staff members up [and] down the hallways complaining loudly . . ." *10/23/13, 6:48p.m. - "See order to dc [discontinue] wander guard." *10/24/13, 5:30 p.m. - "No wandering or attempts to exit." *12/26/13, 1:21 p.m. - "Had her winter coat on stating she was going to walk to her house and a family members house in Arthur. Informed she's unable to do this without an escort, upset by this, angrily returned to her room" *01/30/14, 2:55 p.m. - ". . . She like [sic] to walk around the facility and states she can't wait until it becomes warmer out so she can go outside. . . ." *03/20/14; 6:51 p.m. - "Call received from a community member that she saw [Resident #3's name] walking East of AGS [Arthur Good Samaritan], staff out to redirect her." *03/21/14, 3:07 p.m. - "wandergrd [wander guard] to ankle. . ." The record lacked evidence facility staff notified the physician of Resident #3's elopement risk. Resident #3's current care plan stated Problem: "The resident has potential for elopement R/T	F 323		

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F 323	Continued From page 9 [related to] Alzheimer's Disease, exhibits wandering behavior, exit seeking behavior, history of elopement and recent elopement episode of 03/20/14," and Interventions: "Redirect, . . . reassurance . . . validation . . . PERSONAL ALARM: Wander Guard used to alert staff to resident's movement and to assist staff in monitoring movement, and Use sign in/out sheet at the nurses' station." An investigation report, dated 03/20/14 at 6:13 p.m., stated, "[Resident's name] left facility [without] being seen by staff, feel she went out front doors as staff present at [north and south] halls. Seen . . . walking east of her house." Staff informed to initiate 15 min [minute] checks through night. . . ." The record lacked evidence facility staff completed an elopement assessment as per facility policy. During an interview on 04/03/14 at 10:45 a.m., a supervisory staff member (#6) identified Resident #3 had been admitted to the facility with a wander guard. Review of Interdisciplinary Progress Notes identified the physician discontinued use of a wander guard on 10/23/13. During the interview on 04/03/14, the supervisory staff member (#6) stated she should have completed an assessment to determine the appropriateness of removal of the wander guard for Resident #3. 2. Based on record review and staff interview, the facility failed to ensure each resident received the necessary supervision and assistance devices to prevent accidents for 1 of 1 sampled resident with an unreported injury to their toes (Resident #5). Failure to provide foot support resulted in injury to the resident's toes. Failure to provide foot support	F 323		

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F 323	Continued From page 10 during transport places all residents at risk of injury. Findings include: Review of Resident #5's medical record occurred on April 01-03, 2014. The facility admitted the resident in March 1995. Current diagnoses included multiple sclerosis (MS) and pain. Nurse's Progress Notes stated the following regarding Resident #5's left toes: *12/18/13 at 11:52 a.m., "Skin on Lt [left] 2, 3, 4 toes rubbed against the carpet with transport back to her rm [room] from tub rm. Areas at base of toenails & [and] [sic] are very superficially excoriated. Areas left open to air & shoe left off. Will monitor daily." *02/04/14, "Scabs on toes." *02/14/14, "Resolving." *02/25/14, "Healed." Resident #5's annual Minimum Data Set (MDS), dated 12/12/13, identified the resident required total assistance of two or more persons for transfers, walking did not occur, and had functional limitations in range of motion in both lower extremities. An MDS care planning note, dated 01/03/14, identified the resident's lower extremities and feet were at risk for skin breakdown. Resident #5's care plan, in use on 12/18/13, dated 09/17/13, stated "Problems . . . Impaired physical mobility r/t [related to] MS. Potential for skin breakdown d/t [due to] immobility . . . Has no voluntary movement to bil. [bilateral] LE's [lower extremities] . . . Plans . . . Transfer: 2 assist w [with]/total mechanical lift . . . Mobility: assist of 1	F 323		

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F 323	Continued From page 11 w/wc [wheelchair] assist. . . ." Failure to provide foot support resulted in excoriations to Resident #5's left toes which required more than two months to heal. During interview, on the afternoon of 04/03/14, an administrative nursing staff member (#4) reported the tub chair in use at the time of the incident lacked foot rests.	F 323	F-Tag 333 1. Resident #11's insulin orders and times scheduled were reviewed. Nurse #8 was counseled on medication error related to wrong time and not following order written. Nurse #8 was audited on Good Samaritan Verification of Insulin Administration Competency and became compliant.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure administration of insulin occurred consistent with the physician's orders for 1 of 1 supplemental resident (Resident #11) identified with insulin dependent diabetes. Failure to administer NovoLog (a rapid-acting insulin) at the correct time may result in a low blood sugar (hypoglycemic) event. This practice may negatively impact all diabetic residents residing at the facility. Findings include: Review of Resident #11's medical record occurred on April 2-3, 2014 and diagnoses included brittle diabetes. Physician orders included three units of NovoLog insulin scheduled for 5 p.m. daily, and a sliding scale dose	F 333	2. All insulin dependent diabetic residents have the potential to be affected. 3. All nursing staff were educated at a nursing meeting held on May 5th on Medication Errors and Insulin Administration Competency Verification was done on all nursing staff on insulin administration. 4. Deficiency corrected on 5-5-2014 5. Director of Nursing will audit insulin injection times and accuracy with medication passes /EMAR. This will be done randomly on diabetic residents, monitoring 5 medication passes weekly X 1 month, then monthly X 5 months. Findings will be presented to QA Committee for review.	

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F 333	Continued From page 12 scheduled for 5:30 p.m. after meals to ensure Resident #11 ate. The sliding scale included an additional dose of NovoLog insulin based on the resident's glucose level. For a blood glucose between 201 and 250 milligrams per deciliter (mg/dl), the physician ordered seven units of NovoLog. During observation on 04/01/14 at 5:00 p.m., a nurse (#8) administered Resident #11's scheduled dose of three units of NovoLog insulin and the sliding scale dose of NovoLog insulin of seven units based on a blood glucose of 236 mg/dl. The nurse failed to administer the sliding scale portion of the insulin after the meal as ordered. Review of Resident #11's medication administration record (MAR) between March 1 and April 1, 2014 showed Resident #11's blood glucose, performed before meals and at bedtime daily, ranged from 42 mg/dl to 410 mg/dl. During interview on the afternoon of 04/02/14, an administrative nurse (#4) confirmed awareness of the physician's order to administer sliding scale insulin after meals for Resident #11 and stated the reason for this is because Resident #11 is a brittle diabetic.	F 333		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363		

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F 363	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, daily menu review, policy and procedure review, and staff interview, the facility failed to meet the nutritional needs of residents by not serving correct portion sizes for 2 of 2 observations (noon and evening meal on 04/02/14) of tray line service. Failure to follow specified portion sizes as identified in the facility's menu may result in inadequate nutritional intake and potential weight loss. Findings include: Review of the facility's policy titled "Portion Control" occurred on the afternoon of 04/03/14. The policy, dated March 2009, stated, " . . . The portion sizes listed on the menu extensions will be followed. Portion sizes for menu extensions must be referred to during meal service . . . ." - Observation of lunch tray line service occurred on 04/02/14 at 12:00 p.m. A dietary staff member (#1) stated 2 ounce serving scoops are used for the ground meat, pureed meat, pureed vegetable, and mashed potatoes. The current menu identified a 3 ounce portion for the ground meat and a 1/2 cup (4 ounce) portion for the pureed meat, pureed vegetable and mashed potatoes. Observation showed the staff member used a slotted, non-measuring spoon to serve the regular vegetable. The menu identified a 1/2 cup (4 ounce) portion for the regular vegetable. - Observation of the evening tray line occurred on 04/02/14 at 5:15 p.m. A dietary staff memer (#2) stated a 3 ounce serving scoop is used for the	F 363	F-Tag 363 1. The residents needs were met when Dietary Manager changed out spoons/serving scoops to accurate/required sizes related to all types of diets. 2. All residents nutritional needs have the potential to be affected. 3. Dietary Manager will in-service all dietary staff on May 7th 2014 regarding portion sizes and proper use of correct serving scoops. 4. Compliance completed 5-7-2014 5. Dietary Manager will audit portion control with correct serving utensils, weekly X 1 month, then monthly X 6 months. All audits will be reported to QA meeting for further Recommendation.	

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F 363	Continued From page 14 pureed sandwich. The current menu identified a 1/2 cup (4 ounce) portion for the pureed sandwich. Interview of the dietary staff member (#2) identified five residents received pureed diets and 3 residents received ground meat. During an interview on 04/03/14 at 10:50 a.m., an administrative dietary staff member (#3) confirmed dietary staff should review the menu prior to serving tray line to ensure the usage of the correct portion sizes/serving utensils.	F 363		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the facility failed to store and prepare foods in a safe and sanitary manner for 1 of 1 kitchen. These practices placed food at risk for contamination which may result in food borne illness when consumed by residents. Findings include: Review of the facility's policies occurred on the morning of 04/02/14. The policies included:	F 371		

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F 371	Continued From page 15 "Sanitation Kitchen General," dated 2008, stated, " . . . All food contact surfaces will be washed, rinsed, and sanitized as follow: a. After each use . . . Wiping cloths are always available to wipe down equipment and spill. Wiping cloths are clean, rinsed frequently in a sanitizing solution and stored in sanitizing solution between uses . . . Wash, rinse and sanitize cutting boards after each use and after each food. . . ." "Food Storage," dated March 2009, stated, " . . . all foods will be stored six inches off the floor and away from the wall . . . Chemicals will not be stored near food items. . . ." - A dietary tour occurred on 04/01/14 at 3:00 p.m. Observation of the kitchen showed the following: *Food debris on the underside of the head of a standing mixer, covered to indicate ready for use. *Food debris on a cutting board stored ready for use *One pastry brush and three rubber scrapers with rough, uncleanable surfaces *One wiping cloth on a hand sink and one wiping cloth in the dish room not stored in sanitizing solution. *Chemicals, disinfecting wipes and rubbing alcohol, stored alongside a food item, black pepper *Seventeen boxes of food products stored on the floor of the walk-in freezer During an interview on 04/01/14 at 4:00 p.m., an administrative dietary staff member (#3) confirmed dietary staff should ensure equipment is clean and sanitized, store wiping cloths in sanitizing solution, store chemicals separate from food, and store boxes off the floor.	F 371	F-Tag 371 1. All resident needs were met when Dietary Manager removed boxes from floor of freezer, disposed of scrapers and replaced, washed mixer, removed chemical away from food storage and cleaning rags place in appropriate sanitation solution. 2. All residents have the potential to be affected. 3. Dietary Manager will hold In-service on May 7th 2014 to address sanitary conditions of kitchen, proper food, chemical and wiping cloth storage. 4. Compliance completed on 5-7-2014. 5. Dietary Manager will audit cleaning schedule to include mixers, floor surfaces, rags in sanitization solution. Cupboards will be monitor to assure no chemical and food are place together. This audit will be done weekly X1 month and monthly for 6 months. Audits will be reviewed by QA committee.	

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F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's product instructions, review of facility policy, record review, and staff interview, the facility failed to identify an expired vial of insulin during 1 of 3 observation of insulin administration, administered to 1 of 1 supplemental resident (Resident #11). Failure to identify expired insulin may result in use exceeding the manufacturer's recommendations and affect the potency and efficacy of the medication. Findings include:	F 425	F-Tag 425 1. All Insulin vials were observed on 4-4-2014 to ensure there were no outdated/expired insulin vials. Nurse # 7 was instructed on expiration of Insulin vials and proper dating. She became compliant. 2. All diabetic residents on insulin has the potential be affected. 3. Nursing In-service held on May 5, 2014. Pharmacy Consultant provided education on insulin administration and expiration/dating of vials. 4. Correction completed on May 5, 2014 5. Director of Nursing will audit medication and treatment carts for outdated insulin and medications weekly X 1 month, and then monthly X 3 months. Consultant Pharmacist will monitor All expired medications at their monthly visit. Findings will be reported to QA Committee for recommendations.	

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F 425	Continued From page 17 The Nursing 2013 Drug Handbook, page 736 stated, ". . . Opened vials of NovoLog Mix 70/30 and opened vials and cartridges of NovoLog are stable at room temperature for 28 days. . . ." Review of the facility policy "Administration of Medication" occurred on 04/03/14. The policy, dated January 2014, stated: ". . . Purpose: To promote therapeutic effects of prescribed medication. . . . To promote good health and well-being . . . 7. For medication designed for multiple administrations (e.g., inhalers, eye drops, insulin), a label is affixed in a manner to promote administration and the multi-dose will have the open date listed on the label. . . . Maximize the effectiveness (optimal therapeutic effect) of the medication (for example . . . insulins . . .)" - During observation of medication pass on 04/01/14 at 5:00 p.m., a nurse (#7) prepared an injection of NovoLog insulin for Resident #11. After the nurse prepared the injection, the surveyor asked to see the vial and questioned what the date on the label meant. The nurse (#7) stated the label, dated 02/21/14, indicated when the vial was opened. The nurse asked if she should get a new vial. Without direction, the nurse disposed of the insulin syringe and went to the medication room to obtain a new vial of Resident #11's insulin. Upon return, the nurse labeled the vial with the open date and prepared a new syringe of insulin. Review of Resident #11's record identified the resident as a brittle (unstable) diabetic. Review of Resident #11's medication administration record (MAR) from March 1, 2014 through April 1, 2014 identified Resident #11 received a scheduled dose of NovoLog insulin twice daily and a sliding	F 425		

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F 425	Continued From page 18 scale dose as needed three times a day. Using expired insulin affects the potency and has the potential to adversely affect Resident #11's blood glucose levels. The insulin vial remained available in the medication cart for two weeks following its expiration. During interview on the morning of 04/03/14, an administrative nurse (#4) stated vials of insulin should not be used when outdated.	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. The facility must provide separately locked,	F 431		

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F 431	Continued From page 19 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 and staff interview, the facility failed to restrict access of 1 of 1 medication room to only authorized personnel. This practice may affect the security of medication stored in the medication room. Findings include: On the afternoon of 04/02/14, a nurse (#7) identified personnel with keys to access the medication room included a maintenance supervisory staff member and a non-nursing administrative staff member. Observation showed the counter in the medication room contained a bin which stored several different residents' medications, and above the counter an unlocked cupboard which contained several bottles of stock medication. On the morning of 04/03/14, a supervisory maintenance staff member (#5) stated he had access to the medication room in the event the nurses locked the keys in the room. On the morning of 04/03/14, an administrative nurse (#4) stated the facility lacked a policy	F 431	F 431 1. On 4-8-2014 The medication room door lock/keys were changed. New keys were given to licensed nurses on treatment and medication carts. These key are only available for usage while on duty. Emergency keys were given to DON and Resident Coordinator. 2. All staff and residents have the potential to be affected. 3. On 4-8-2014 a memo was sent out to all nurses to notify them of lock and key change to medication room. With explanation provide on citation of this F-Tag. Pharmacy consultant notified on 4-8-2014. Nurses meeting held on 5-5-201 reviewing who has access to the medication room and availability of keys. DON on an ongoing basis will know who has keys to access the medication room. 4. Correction completed on 4-08-2014. 5/5/14 RN T.C & DON, DQ. 5. Medication Room Access audit will be Done weekly X 1 month and then monthly x 6 months by DON. These findings will be reported to QA committee for review.	

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F 431	Continued From page 20 regarding who can have access to the medication room.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		

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F 441	Continued From page 21 infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and staff interview, the facility failed to follow infection control standards on 2 of 2 days (April 01-02, 2014) of observation of medication administration/pass. Failure to follow infection control standards during medication pass may result in contamination and exposure of bloodborne pathogens to residents, staff and visitors. Findings include: Review of the following facility policies occurred on 04/03/14: * "Cleaning and Disinfecting Blood Glucose Meters," dated November 2011, stated, "NOTE: It is preferable that each resident has his/her own glucose meter. This procedure is for cleaning and disinfecting a glucose meter when it is being used between multiple residents. PURPOSE: To provide proper cleaning methods for glucose meters and to avoid cross-contamination issues . . . Cleaning: 1. Clean the outside of the meter . . . Disinfecting . . . After the disinfecting is complete . . . the meter should be left for a few minutes to ensure it is dry. . . ." * "Blood Glucose Monitoring," dated November 2013, stated, ". . . Procedure: . . . Perform hand hygiene and put on gloves. . . . Wipe the intended puncture site with an alcohol pad or wash with soap and water and let dry. . . . Prepare drop of	F 441	F-Tag 441 1. The needs of residents #1, #8, and # 11 were met when nurses #6 and #7 were educated on hand washing and glove, usage per Good Samaritan Society Policies on Hand Hygiene and Hand washing/ Standard Precautions. Nurse #6 and 7# completed Infection Control audit on hand washing and glove usage. Nurses #6 and # 7 became compliant with this standard of care. 2. All residents have the potential To be affected. 3. Staff Education was provided to all staff at in-services held on 4/21, 22, and 23rd/2014. Infection Control measures with hand washing and glove usage was reviewed Nursing staff were instructed on Proper glucometer usage, Cleaning and storage on 5-9-2014 4. Deficiency corrected on 5/09/2104.	

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F 441	Continued From page 22 blood . . . Wipe resident's finger clean; apply a small adhesive bandage if necessary. . . . Clean and disinfect the blood glucose monitor between each resident. . . ." * "Administration of Medication," dated January 2014, stated: ". . . Perform hand hygiene prior to beginning the medication pass and following the administration of medication for each resident. . . ." * "Hand Hygiene and Handwashing," dated 11/13, stated, "Purpose: To ensure appropriate hand hygiene technique . . . Use of Alcohol-Based Hand Rub: 1. Apply 1.5 to 3 ml [milliliters] (about the size of a quarter) of an alcohol gel or rinse to palm of one hand. 2. Rub hands together. 3. Cover all surfaces of hands and fingers and areas around/under fingernails. 4. Continue rubbing hands together until alcohol dries (about 15 to 25 seconds). 5. Make sure hands are completely dry prior to putting on gloves." - Observations of insulin administration occurred on 04/01/14 between 4:45 p.m. and 5:10 p.m. A nurse (#7) performed blood glucose monitoring (accuchecks) on Resident #1 and #11 and administered insulin to Resident #1, #8 and #11. The following occurred: * At 4:45 p.m., the nurse (#7) gloved, cleansed Resident #1's finger with an alcohol wipe, used a lancet to puncture the skin, obtained a drop of blood directly onto an accucheck strip, gave the resident a cotton pad to apply pressure to the puncture site, returned the glucose meter with the strip to the medication cart, removed the strip with the gloved hand and disposed of the strip into the contaminated waste (red) container on the medication cart, and placed the glucose meter	F 441	F-Tag 441 cont. 5. Staff Development coordinator Will observe all staff responsible for resident care, completing 10 infection control audits with hand washing/appropriate glove usage and glucometer usage to include proper cleaning and storage. Reviewed weekly x 1 month and then monthly X 6 months. The results of this audit will be reported to Quality Assurance Committee for further recommendations.	

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F 441	Continued From page 23 into a plastic container on the medication cart which contained other accucheck supplies (gauze, lancets, alcohol wipes). With the same gloved hands, the nurse entered the top drawer of the medication cart, touched two resident's insulin vials before finding Resident #1's vial, and after cleaning the port with an alcohol wipe, withdrew Resident #1's scheduled insulin dose. With the same gloved hands, the nurse administered Resident #1's insulin, returned to the medication cart, disposed of the syringe in the contaminated waste container, and with the same gloves, documented on the screen of the electronic record the administration of the insulin. The nurse then removed the gloves, failed to perform hand hygiene and donned a new pair of gloves. After the observation, when asked regarding placement of the glucose meter into the plastic storage bin, the nurse stated she cleans the accucheck before the next resident and after use with the last resident. * At 5 p.m., after wiping off the glucose meter with a disinfectant wipe, the nurse (#7) entered Resident #11's room and performed an accucheck in the same manner as Resident #1. Upon completion, the nurse failed to remove her gloves and perform hand hygiene. Wearing the same gloves, the nurse obtained Resident #11's insulin in the top drawer of the medication cart, wiped the port with an alcohol wipe, and withdrew Resident #1's scheduled insulin, and noted the vial of insulin was expired. The nurse, donned with the same gloves, obtained keys for the medication room and before unlocking the medication room door, removed one glove and after entering the medication room, removed the second glove. The nurse failed to perform hand hygiene after removal of the gloves. After	F 441		

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F 441	Continued From page 24 obtaining an insulin vial in the med room, the nurse returned to the med cart, donned new gloves, withdrew insulin from the vial, entered Resident #11's room, administered the insulin, removed the gloves and failed to perform hand hygiene. * At 5:10 p.m., prior to applying new gloves, the nurse (#7) performed hand hygiene with alcohol based hand rub (ABHR), and prepared Resident #8's insulin, entered the resident's room and administered the insulin into Resident #8's abdomen. The nurse failed to remove the gloves and perform hand hygiene before leaving the room. Upon return to the medication cart, the nurse removed her gloves, wiped down the accucheck meter with a disinfectant wipe and then used to the wipe to cleanse the tips of her fingers. * During observation of medication pass on the morning of 04/02/14, between administration of medications for two residents, a nurse (#6) performed hand hygiene with ABHR. The nurse did not cover all surfaces of her hands and fingers and areas around/under fingernails and rub her hands together until the ABHR dried prior to obtaining a medication cup for the next resident. During interview on the afternoon of 04/02/14, an administrative nurse (#4) agreed nurses should perform hand hygiene between residents during medication pass and clean the blood glucose meter after use with each resident.	F 441		