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 _____	05/19/2011

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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 05/16/11 and completed on 05/19/11, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000	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.	
F 225 SS=B	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	F 225 06/15/2011 1. Resident # 11 expired 04/02/2011; cause of death was dementia, not related to unsubstantiated allegation of abuse. 2. All resident's have the potential to be affected. 3. Randi Streff, RN, DNS was provided education from the Administrator 05/19/2011 regarding the Memorandum issued by Bruce Pritschet, Director, Division of Health Facilities on 01/08/2010 titled Reporting Allegations of Mistreatment, Neglect, and Abuse,	

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Valerie A. Eide | Administrator | 6-9-11

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ır safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 ıram participation.

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F 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to immediately report an allegation of neglect to the administrator and to the state survey and certification agency, and failed to report the findings of the investigation to the state survey agency within five working days of the incident for 1 of 2 allegations investigated in the past year (June 2010-May 2011). Failure to immediately notify the administrator of an allegation of neglect could result in the alleged staff member continuing to provide care to residents. Findings include: Review of the facility policy "Abuse and Neglect" occurred on 05/19/11. The policy, revised 10/2009, stated, "Notification Procedures: a. Notify the center administrator immediately of any incidents of resident . . . alleged or suspected . . . neglect . . . In case of absence of the administrator, follow the chain of command for notification . . . 'Immediately,' in this procedure means 'as soon as possible after discovery of the incident, and ought not to exceed the end of the shift . . ."	F 225	including injuries of Unknown Source and Misappropriation of Resident Property including section IV Reporting Guideline which states "Immediate initial Report of Allegation (as soon as possible, not exceeding 24 hours) are to be submitted via one of the following methods." A mandatory meeting for nursing staff was held on 06/09/2011 to provide education on the above mentioned Memorandum and the Good Samaritan Society Procedure titled Abuse and Neglect. A general staff meeting will be held 06/15/2011 to educate staff on the Good Samaritan Society Procedure titled Abuse and Neglect. 4. Social Services Director or her designee will be responsible to complete the Abuse/ Neglect focus audit one time per month for six months. The results of the audits will be reported to QA/CQI committee for further recommendation.	

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F 225	Continued From page 2 Review of facility investigations of alleged abuse and/or neglect occurred on the morning of 05/19/11. A "Resident/Visitor Incident Report," dated 08/13/10, identified, on 08/12/10 at 4 a.m., staff found Resident #11 on the bedpan. The report stated, "Skin assessment [with] [no] bruising. Redness/skin breakdown around lower back and hips in shape of bedpan." A second incident report, dated 08/15/10, identified a "sore in inner (R) [right] buttock 1 cm [centimeter] by 1 cm - may have got it from bed pan." The report, dated 08/13/10, identified staff notified the administrator on 08/13/10 at 1:15 a.m. The report further identified the administrator notified the state survey agency of the results of their investigation on 08/27/10 at 3 p.m., 15 days after the incident. During an interview on the morning of 05/19/11 an administrative nurse (#1) stated nursing staff do not call administrative staff at home if incidents occur outside work hours. She stated staff leave messages on the administrator's work voice mail. The administrator receives the message on the next work day, which in this case would have been the morning of 08/13/10. The nurse (#1) provided no evidence the facility notified the state survey agency prior to 08/27/10.	F 225		
F 431 SS=D	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	F 431	F 431 06/15/2011 1. The residents identified as insulin dependent diabetics have shown no adverse effects and their needs have been met by adjusting the refrigerator temperature to 36-40 degrees Fahrenheit.	

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F 431	Continued From page 3 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, 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, record review, review of medication labels, review of professional literature, and staff interview, the facility failed to store medications at the proper temperature in 1 of 1 medication refrigerator. Failure to maintain the temperature within an acceptable range has the potential to affect the potency and efficacy of	F 431	2. All residents whose medication regimen includes insulin have the potential to be affected. See attachment. 3. On 05/18/2011 the temperature log was revised to include acceptable range for temperature of 36-40 degrees Fahrenheit. On 05/18/2011 a reminder was posted on the 24 hour communication logs and a memorandum was sent out to all nursing staff regarding appropriate temperature ranges. A mandatory meeting for nursing staff was held on 06/09/2011 to provide education regarding appropriate temperatures for storage of insulin. All staff were provided a copy of Diabetes Care by the American Diabetes Association, Inc., January 2004, Vol 27, Supplement 1. See attachment.	

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F 431	Continued From page 4 the medication. Findings include: Diabetes Care by the American Diabetes Association, Inc., January 2004, Vol. 27, Supplement 1, stated, ". . . Insulin Administration. . . Storage. . . Extreme temperatures ([less than] 35 [degrees Fahrenheit]) should be avoided to prevent loss of potency, clumping, frosting, or precipitation. Specific storage guidelines provided by the manufacturer should be followed. . . ." A tour of the medication room occurred on 05/18/11 at 8:30 a.m. with a licensed nurse (#2) and a certified medication assistant (CMA) (#3). Observation showed the temperature in the medication refrigerator at 34 degrees Fahrenheit (F). Observation identified the following medications stored in the refrigerator: multidose vials of Lantus insulin, Novolog insulin, Novolin 70/30 insulin, pneumococcal vaccine, and Lantus insulin pens. Review of the medication labels identified the Novolog 70/30 vials stated "Avoid freezing." All other labels stated to store the medication at 36 to 46 degrees F. The staff members (#2 and #3) stated they were not aware the medications should be stored within that range. Review of the temperature log identified the following at the bottom of the page, "Proper Temperature Range: Refrigerator - below 40 degrees." Review of the temperature log for the month of May 2011 identified for all 18 days, the temperature in the medication refrigerator measured 33 degrees F or less. On eight days, the temperature was below 30 degrees F creating	F 431	4. Charge Nurse will check refrigerator temps nightly per Good Samaritan Society Policy and Procedure. An audit tool has been developed to monitor refrigerator temperatures to assure the appropriate temperature is maintained; the audit will be completed one time per week for four weeks and then two times per month for 2 months. The results of the audits will be reported to QA/CQI committee for further recommendation.	

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F 431	Continued From page 5 a potential for ice crystals to form in the medication and affect potency. Review of the temperature log for the month of April 2011 identified on 20 days the temperature in the medication refrigerator was 34 degrees F or less. Information provided by the facility on the afternoon of 05/18/11 identified 11 insulin dependent diabetics in the facility. Observation on 05/19/11 at 8:45 a.m. with a CMA (#3) identified the temperature in the refrigerator remained 34 degrees. Review of the temperature log showed in the past 24 hours, the temperature ranged from 34 to 38 degrees F. An administrative nurse (#1) stated staff had been attempting to adjust the temperature, but when the refrigerator reached an appropriate range, the contents of the freezer thawed. When asked, the nurse (#1) stated the facility policy for medication storage did not address temperature ranges.	F 431		
F 495 SS=B	483.75(e)(4) NURSE AIDE WORK < 4 MO - TRAINING/COMPETENCY A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual is a full-time employee in a State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or has been deemed or determined competent as provided in §§483.150(a) and (b). This REQUIREMENT is not met as evidenced	F 495	F 495 06/15/2011 1. CNA #4 tested and became certified 03/24/2011 2. All resident's who are cared for by a CNA who is not currently attending a Nurse Aide Training Program and is not certified have the potential to be affected. 3. On 6/8/2011 Staff Development Coordinator was educated on the Good Samaritan Society Policy and Procedure titled Registry/Licensure Verification including the Registry/Licensure Verification Form from the Good Samaritan Society Human Resources Manual. 4. Staff Development Coordinator will complete the Quality Round titled Staff Development Monthly for six months. The results of the audits will be reported to QA/CQI committee for further recommendation.	

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F 495	Continued From page 6 by: Based on review of the state nurse aide registry files, facility record review, and staff interview, the facility failed to ensure current certification or deemed competency for 1 of 7 certified nursing assistants (CNAs) (CNA #4), hired in the past four months and working with residents. Failure to ensure certification/competency of caregivers has the potential to affect resident care. Findings include: Review of the facility policy titled "Registry/Licensure Verification" occurred on 05/18/11. This policy, dated 01/2010, stated, "Purpose . . . To ensure compliance with applicable laws and regulations. . . . Policy . . . all employees with positions requiring certification . . . provide proof . . . certifications are current. . . . Procedure . . . 3. New employees must present all required . . . certifications . . . on or before their first day of employment . . ." On 05/17/11, review of facility personnel records for a CNA (#4) identified a hire date of 01/31/11. The CNA tested and became certified on 03/24/11. Review of facility schedules, provided by an administrative nurse (#1), identified the CNA (#4) started orientation on 03/14/11 and worked a total of 7 shifts prior to testing on 03/24/11. During an interview, on 05/19/11 at 9:15 a.m., the CNA (#4) confirmed she worked with another CNA caring for residents before testing and becoming certified on 03/24/11. She stated she was certified in the past and challenged the test	F 495		

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F 495	Continued From page 7 on 03/24/11. Review of the state nurse aide registry files identified certification of the CNA (#4) on 09/24/02. The certification expired on 09/24/04.	F 495		