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 _____	06/03/2010

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 06/01/10 and completed on 06/03/10, 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 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, professional standard review, record review, and staff interview, the facility failed to provide medically related social services to 1 of 1 sampled resident (Resident #3) who experienced a death of a family member in the last three months. The failure of the facility to assess the reason/causative factors of the behaviors or assist the resident through the grieving process, resulted in the resident not receiving the care/services needed to assist the resident through this difficult period and deal with psychosocial needs. Finding include: The Centers for Medicare and Medicaid (CMS) has defined, "Medically-related social services" to mean services provided by the facility's staff to assist residents in maintaining or improving their	F 250	F 250 1. Resident #3's individual needs have been met by having the Social Service Director provide one to one assistance; they discussed his current mood related to the death of his grandson and offered him services per his request. Res. #3 MDS will be reviewed for accuracy and if he meets the criteria for a significant change or significant correction of the MDS. Res. #3's care plan will be	7/8/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bruce Donerson | TITLE: Administrator | (X6) DATE: 6/28/10

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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F 250	Continued From page 1 ability to manage their everyday physical, mental, and psychosocial needs. These services might include, for example: providing alternatives to drug therapy or restraints by understanding and communicating to staff why residents act as they do, what they are attempting to communicate, and what needs the staff must meet; meeting the needs of residents who are grieving; and finding options which most meet their physical and emotional needs. . . Types of conditions to which the facility should respond with social services by staff or referral include: behavioral symptoms, depression, and need for emotional support. Resident #3's medical record, reviewed June 1-3, 2010, identified the facility admitted the resident in July 2009 with diagnoses which included depression, dementia, and insomnia. Review of Resident #3's nurses notes included the following; * 05/15/10, 6:00 p.m., ". . . Noted increase in requests to toilet, leaning to the L [left] in his w/c [wheelchair], daughter here to inform res. [resident] his grandson [name] passed away this am, vm [voice mail] left for Pastor [name]. . . " * 05/16/10, 6:00 p.m., ". . . Pastor [name] to visit res. . . " * 05/17/10, 6:00 a.m., "Res has been awake most of noc [night] . . . " * 05/17/10, 6:30 p.m., "Grandson's funeral scheduled . . . res aware . . . " * 05/20/10, 3:15 a.m., "Resident awake most of noc. On call light frequently. . . PRN [as needed] Seroquel [antipsychotic medication] not effective in calming resident . . . " * 05/20/10, 9:00 a.m., "Out [with] staff to grandson's funeral . . . " * 05/21/10, untimed, ". . . slept until 11 p.m. then	F 250	reviewed and updated to reflect current problems related to his current mood status and from his grandson's death. 2. All residents that have had a recent loss of a loved one may have the potential to be affected. Social Service Director will review all residents' MDS section F #2, which states if the resident has had a recent loss of a close family member. Social Services Director will provide one to one visits to the identified residents and update care plans as needed related to grief and loss. 3. Administrator will provide training to the social services director on 6/28/10. "Grief and Loss Intervention" and "Reaching Out to the Grieving Person" from the Good Samaritan Society Social Services Manual will be reviewed. 4. Social Service Director, or designee, will be responsible to complete the Grief and Loss Focus Audit one time per month for 6 months. The results of the audits will be reported to QA/CQI committee for further recommendation.	

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F 250	Continued From page 2 pt [patient] was constuly [sic] on his call light . . . " * 05/22/10, 5:00 a.m., "Pt was up all night extremely agitated, yelling . . . " Review of Resident #3's "Mood and Behavior Records" for the months of March, April, and May 2010 occurred on June 02, 2010. This record indicated during the month of March, Resident #3 had three days with behaviors noted, April indicated no behaviors, and in May behaviors noted on the following days, 16, 21, and 23. The Minimum Data Set dated 04/13/10, showed no long term memory problem, and no behavioral symptoms. Review of a psychiatric progress note, dated 05/24/10, stated, " . . . 24 yr [year old] grandson recently died. [name] was able to attend funeral, very sad - told staff 'it should have been me.' More confused over the past wk [week] since this happened. . . . " Resident #3's Social Service notes, or care plan failed to include any assessment or interventions for the increased emotional needs the resident may have experienced. During an interview on 06/03/10 at 10:30 a.m., an administrative staff member (#2) acknowledged knowing about Resident #3's grandson passing away and that the resident attended the funeral. The staff member(#2) could not identify any additional interventions that were implemented to help Resident #3 with the grieving process or address his increased mood/behavior problems.	F 250	F 281 1. Residents # 1,2,5,6,7, and 8 individual needs have been met by ensuring proper timing and documentation of each of the drug regimens, according to acceptable standards of practice. 2. All residents that receive medication have the potential to be affected. The changes will be made at the facility will ensure proper medication administration for all residents including a review of all MAR's by 6/24/10 and medications were timed according to Administration Guidelines found in the "Nursing 2010 Drug Handbook," 30th Edition, Lippencott, Williams, and Wilken; and the current physician orders. 3. A mandatory Licensed Nursing meeting was held on 6/23/10 to educate staff on the new procedure titled "Administration of Medication". This includes the timing of medications and the need to administer a medication close to the same time each day to maintaining the appropriate therapeutic medication levels. 4. An audit tool has been developed to monitor MAR's on the timing of medications versus AM/PM. The audit will be completed one time per week for 4 weeks, then	7/8/10
F 281 SS=B	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		

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F 281	Continued From page 3 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, professional reference, and staff interview, the facility failed to ensure staff administered medications according to acceptable standards of practice for 6 of 9 sampled residents (Resident #1, #2, #5, #6, #7, and #8) and 1 supplemental resident (Resident #11). Failure to establish a specific time for medication administration does not ensure staff administer medications at the same time each day and at regular intervals, resulting in an inability of residents to maintain the appropriate therapeutic medication levels. Findings include: Taylor, Lillis, Lemone, "Fundamentals of Nursing, The Art and Science of Nursing Care," 4th ed., J.B. Lippincott Company, Pennsylvania, page 581, stated: "The five rights help to ensure accuracy when administering medications. The nurse gives the (1) right medication to (2) the right patient in the (3) the right dosage through the (4) the right route at the (5) right time." Review of the facility policy "Timing of Medications" occurred on 06/03/10. The policy, dated February 2004, stated, "The majority of every day and BID (twice a day) medications will be timed as 'AM' and/or 'PM' rather than utilizing a specific time of day for the medication to be given (e.g. [such as] 8:00 AM). The following are exceptions to this rule: a) psychoactive medications ordered for specific times by the	F 281	two times per month for 2 months. The audit will be completed by the DNS or her designee. The results of the audit will be reported to the QA/CQI committee for further recommendations.	

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F 281	Continued From page 4 psychiatrist. b) medications that are ordered TID (three times a day) or QID (four times a day). These medications will be evaluated on an individual basis. c) medications that the nursing team, nurse practitioner, physician or pharmacist believe require specific times for administrations related to drug levels and/or patient condition." * Information below regarding drug classifications, interactions with other medications, administration with food or before meals, and/or the need to administer at the same time each day is from the Wolters and Kluwer, "Nursing 2009 Drug Handbook," 29th Edition , Lippincott, Williams, and Wilkin. Observation of medication administration occurred on 06/02/10 at 8:20 a.m. Observation showed Resident #11 seated at the breakfast table with her food consumed. The nurse (#7) administered Nifedrac (an antihypertensive), hydralazine (an antihypertensive), hydrochlorothiazide (a diuretic), potassium chloride, ranitidine (an antiulcerative), levothyroxine (thyroid medication), aspirin, docusate and docusate plus senna (stool softeners), and acetaminophen (an analgesic). Review of the Medication Administration Record (MAR) identified the administration time as "AM" for the above medications. Levothyroxine should be given one half to one hour before breakfast. An interview with an administrative nurse (#1) occurred on 06/02/10 at 9:30 a.m. The nurse stated staff administer AM medications between 6 a.m. and 10 a.m., PM medications at suppertime, and HS medications after supper. The staff member (#1) agreed nurses should administer levothyroxine before breakfast.	F 281		

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F 281	Continued From page 5 Review of the MARs for all sampled residents occurred on 06/03/10. Medications with specific times of administration identified on the MAR included insulin, inhalers, nebulizers, coumadin (an anticoagulant), and carbidopa/levodopa (an antiparkinson's drug). The MARs identified administration times for most other medications as "AM," "PM," and "HS [hour of sleep]." The sampled resident's MARs identified the following: - Resident #1 - potassium (AM and PM) - should be taken with or after meals - Resident #2 - omeprazole (AM and PM) an antiulcerative - should be given one half hour before meals, carvedilol (AM and PM) an antihypertensive - should be given with food - Resident #5 - glipizide (AM) an antidiabetic - should be given 30 minutes before meals - Resident #6 - Cipro (AM and PM) an antibiotic - should be given before meals - Resident #7 - calcium with vitamin D (AM) - should be given one hour after meals - Resident #8 - metformin (AM and PM) an antidiabetic - should be given with meals, ferrous sulfate (AM and PM) iron - should be given between meals Failure to administer medications at the same time each day and at regular intervals and to administer medications at the proper time in relation to meals does not allow residents to	F 281		

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F 281	Continued From page 6 maintain the appropriate therapeutic medication levels and obtain optimum results from the medications.	F 281	F284 1. Resident #7 was discharged on 6/11/10. 2. Residents that have the potential to be affected in this area will be identified by reviewing all residents MDS section Q1.c for a score of a 1, 2, or 3, which is stay projected to be of a short duration. System changes made at the center will ensure the individualized discharge plan and update care plans as needed. 3. Social Service Director has read and understands the policy and procedure titled "Discharge Planning and Discharge/Transfer". The Social Service Director will document weekly in the IDP notes an update the care plan as needed. All residents with a 90 day or less anticipated stay at the center will have a updated discharge plan. 4. An audit tool has been made to ensure compliance in discharge planning for all resident stays of 90 days or less. The Social Service Director, or her designee, will be responsible for the completion of the audit 2 times per month for one month, then one time per month for 2 months. The results of the audits will be reported to the QA/CQI	7/8/10
F 284 SS=D	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy, resident and staff interview, the facility failed to assess continuing care needs, and develop an individualized discharge plan for 1 of 1 sampled resident (Resident #7) identified by the facility as planning to transfer or discharge in the next 30 days. Failure to assess and provide sufficient preparation for discharge has the potential to cause unnecessary and avoidable anxiety and prevent the resident from receiving the necessary services to enable her to live safely. Findings include: Review of the facility policy titled "Discharge/Transfer" occurred on 06/03/10. This policy, dated January 2009, stated, ". . . The center will also provide sufficient preparation and orientation to ensure a safe and orderly discharge/transfer. . . ." - Resident #7's medical record, reviewed June 2-3, 2010, identified the facility admitted the	F 284		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 284	Continued From page 7 resident in May 2010 with diagnoses which included bilateral hand fractures, right thumb fracture, left knee laceration, history of falls, depression, and anxiety. During an interview on 06/02/10 at 4:45 p.m., Resident #7 stated that in early May, she fell and fractured both hands. Resident #7 went on to say that she hoped to return to where she was staying before, but "now I need help with everything." Resident #7 stated, "I am working with therapy and when the casts are off, will work more to regain strength and do my own cares again." Review of a Minimum Data Set, dated 05/20/10, identified Resident #7 as needing extensive assistance of one person for transfer, bed mobility, dressing, toilet use, and personal hygiene. Review of Resident #7's progress notes listed an entry by the Social Worker, dated 05/11/10, stated, ". . . Resident hopes to have a short stay et [and] return to her basic care apt [apartment] is on a Medicaid 15 day bed hold." During an interview on 06/03/10 at 9:40 a.m., a therapy staff member (#8) stated, Resident #7 should be finished with therapy next Wednesday and able to return to her apartment by next week. Review of Resident #7's Social Service notes and care plan failed to indicate an individualized discharge plan for this resident. During an interview on 06/03/10 at 10:30 a.m., while reviewing Resident #7's care plan, an administrative staff member (#2) acknowledged she failed to write a discharge plan for this	F 284	committee for further recommendation.	

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F 284	Continued From page 8 resident.	F 284	F 323 1. Resident # 8's individual needs have been met by updating the care plan and diet card to include a "covered mug with handles for coffee". This was communicated to staff via the white board. The Resident/Visitor Incident Report from 6-3-10 was updated to reflect the immediate interventions that have been put in place to prevent this incident from happening again" on 6/3/10. 2. All residents that drink coffee have the potential to be affected. 3. On 6/23/10 a mandatory nursing meeting was held to educate staff on the on the Policy and Procedure for "Resident/Visitor Incident Report" and the training DVD titled "Incident Reports" was shown to staff. On 6/24/10 Coaching and Counseling was provided to Heidi Larson, LPN who failed to use the Resident/Visitor Incident Report for resident # 8 on 4/17/10 when resident #8 spilled coffee. On 6/24/10 Coaching and Counseling was provided to Melanie Flegel, LPN who failed to fully complete the Resident/Visitor Incident Report on 6/1/10 identifying "what immediate interventions have been put in place to prevent this	7/8/10
F 323 SS=D	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: Based on observation, record review, and staff interview, the facility failed to implement measures to prevent injury for 1 of 2 sampled residents (Resident #8) who had episodes of spilling hot coffee. Failure to implement preventive measures placed the resident at risk for sustaining a burn from the hot coffee. Findings include: Review of the facility policy "Resident/Visitor Incident Report" occurred on 06/02/10. The policy, revised 1/09, stated, ". . . All incidents/occurrences occurring within the center or affecting a resident/visitor will be documented, investigated and evaluated to determine contributing factors and to prevent recurrence whenever possible. . . ." Resident #8's medical record, reviewed on June 2-3, 2010, identified diagnoses including peripheral vascular disease, diabetes mellitus, and dementia. An annual Minimum Data Set, dated 05/11/10, identified the resident as	F 323		

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F 323	Continued From page 9 independent with eating, with setup help only. Resident #8's interdisciplinary progress notes identified the following: * 04/17/10 at 5:28 p.m. - "Res [resident] spilled coffee on L) [left] upper abdominal area @ [at] 3 p.m. snack time. Clothing was changed, skin was slight pink immediately [after] incident but [no] redness or blistering was noted @ 30 min [minute] [and] 2 hr [hour] follow-up skin assessments. Res denies any pain . . ." 06/01/10 at 6 p.m. - "Pt [patient] spilt [sic] coffee on her lap this morning [no] apparent injuries at this time. Pt stated no pain will continue to monitor." The record identified an "Incident Details" form, dated 06/01/10 at 9:30 a.m. which stated, "Pt spilt [sic] hot coffee on herself did visual check. Pt did not hit any skin. Landed on her brief." The form identified the incident as occurring in the dining room. The section "What immediate interventions have been put in place to prevent this incident from happening again? Update the care plan with these interventions, if applicable" was blank. The record lacked evidence of a report from the 04/17/10 episode. Review of Resident #8's care plan failed to identify the potential for injury from spilling hot liquids and lacked interventions to prevent another episode from occurring. When interviewed on 06/03/10 at 9:35 a.m., a dietary staff member (#4) stated Resident #8 uses a regular (not covered) cup at meals and received her coffee in a regular cup this morning at breakfast.	F 323	incident from happening again and to update the care plan if applicable". On 6/30/10 a mandatory meeting for dietary staff will be held. Education will be provided on the Procedure titled Communication within the Dietary Department to ensure each resident receives adequate supervision and assistance devices to prevent accidents developed to monitor incident reports to ensure that a new intervention was added to ensure the incident does not reoccur and to monitor the communication of changes made between nursing and dietary. The DNS, or her designee, will choose 5 random charts to audit one time per week for 4 weeks and then monthly for 2 months. The results of the audits will be reported to the QA/CQI committee for further recommendation. An second audit tool has been developed to monitor any recommended dietary interventions written on an incident report and that the interventions get documented on the residents diet card and communicated between the two departments via the white communication board. The audit	

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F 323	Continued From page 10 During an interview on 06/03/10 at 9:40 a.m., an administrative nurse (#1) stated dietary staff are responsible for implementing adaptive equipment, such as covered cups, to prevent spills. She stated she knew of the 06/01/10 episode, but not the episode on 04/17/10. The nurse (#1) stated she received no incident report from that occurrence. She stated she would expect staff to fill out an incident report when a resident spilled hot coffee on themselves. An interview occurred with a dietary supervisor (#6) on 06/03/10 at 9:45 a.m. The staff member stated she implemented a covered cup for Resident #8 after she spilled her coffee on 06/01/10. She stated she was not aware of the episode on 04/17/10 and would have implemented interventions then, if she had known. When asked how she communicated changes to her staff, she stated she records them on a white board in the kitchen, but had not yet recorded the covered cup for Resident #8. She stated adaptive equipment is also recorded on the resident's diet card and in the care plan. She stated she had not yet recorded the covered cup in the diet card or care plan. Observation on 06/03/10 at 10:05 a.m. with a dietary staff member (#5) identified the white board in the kitchen. The board lacked information regarding Resident #8. Review of Resident #8's diet card failed to identify use of the covered cup. Staff's failure to complete an incident report on 04/17/10 did not allow the facility to implement measures to prevent the second episode of spilling hot coffee on 06/01/10. Failure to communicate the implementation of the covered	F 323	will be completed by the DDS, or her designee, one time per week for 4 weeks and then monthly for 2 months. The results of the audits will then be reported to the QA/CQI committee for further recommendation.	

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 _____	06/03/2010

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 323	Continued From page 11 cup to staff placed Resident #8 at risk for sustaining a burn, if she again spilled hot liquid.	F 323		