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 _____	C 05/19/2016

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 and complaint survey started on 05/16/16 and completed on 05/19/16, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, review of facility policy, and information submitted	F 155	1) Resident #3 has discharged from the facility 5-29-2016.	6/23/16

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

Electronically Signed | 06/10/2016

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F 155	Continued From page 1 by the complainant, the facility failed to honor the resident's right to refuse medications for 1 of 9 sampled residents (Resident #3). Findings include: Information submitted by the complainant identified facility staff "force fed" a resident medications, and administered medication on an empty stomach, which should be given with food. Review of the facility policy titled "Medication Administration, Including Scheduling and Medication Aides" occurred on 05/19/16. This policy, revised May 2016, stated, ". . . If the resident chooses not to take the medication, this should be reported to the charge nurse and should be documented on the MAR [medication administration record]. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included end stage renal disease and a history of enterocolitis due to Clostridium difficile (C. diff). The resident's current Minimum Data Set (MDS), dated 04/11/16, identified intact cognition, clear speech, and able to make self understood/understand others. Physician's orders included: "PhosLo (Calcium Acetate) Give 2 capsule [sic] by mouth with meals for supplement. Okay to leave at bedside per physician's orders and resident's request," and "Senna Tablet Give 2 tablets by mouth in the morning for constipation." During an interview on the morning of 05/18/16, Resident #3 stated that on the morning of 04/22/16, she refused to take the PhosLo	F 155	2) All residents have the possibility to be affected in this area and all residents have the right to refuse medications. 3) Immediate education on 5/20/16 and 5/23/16 to educate staff on the resident's right to refuse medications. An all staff meeting on 6-15-2016 to educated staff on the procedure titled, Medication Administration with a focus on the resident right to choose to NOT take medication. Each employee received a copy of the booklet, "Resident's Rights". 4) An audit will be developed and completed by the DNS, or designee, to observe medication passes surreptitiously so that Resident Rights are being respected with accepting and refusing medications. The audit will be completed 2 X per week for 4 weeks, then monthly X 2 months. A summary report will be provided to the monthly QA committee for further recommendations for monitoring to ensure compliance.	

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F 155	Continued From page 2 because she had not eaten breakfast and the PhosLo upset her stomach. She identified she refused the Senna also, because she had a loose stool the previous day. The resident identified the staff member put all her pills on a spoon and "shoved" them in her mouth. The resident stated she did not want to take the pills, but she "got them anyway." Further review of Resident #3's medical record confirmed staff administered the PhosLo and Senna on the morning of 04/22/16, the resident refused breakfast that morning, and had a bowel movement the day before (04/21/16).	F 155		
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		6/23/16

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F 156	Continued From page 3	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud

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F 156	Continued From page 4 control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A notices/files and verified through staff interview, the facility failed to provide adequate written notices to 4 of 4 sampled residents (Resident #2, #4, #5, and #7) or their representatives before Medicare Part A coverage and/or services ended. Failure of the facility to provide timely notices and/or notices that contained the correct contact information for the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), limits the residents ability to exercise their rights related to Medicare Part A. Findings include:	F 156	1) Residents #2, #4, #5 and #7 have been reissued an updated GSS form #980 (Notice of Medicare A Non-Coverage) with the correct QIO's ("KEPRO") name, toll free number, and text number. 2) All residents on a current Medicare A benefit period have the potential to be affected in this area. A list of residents on Medicare A will be generated. Each resident's Medicare A stay will be tracked and when appropriate will receive a timely notice, with the correct QIO name ("KEPRO"), toll free number, and text	

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F 156	Continued From page 5 The Medicare Part A notices/files for Resident #2, #4, #5, and #7 were reviewed on 05/19/16. The facility's Notice of Medicare Non-Coverage form (CMS 10123-NOMNC) contained a space for the facility to insert the QIO's name, their toll free number, and the text telephone (TTY) number. The following Notices of Medicare Non-Coverage forms failed to have the correct KEPRO name, toll free telephone number, and text number: * Resident #2's - signed 03/24/16. * Resident #4's - signed 04/22/16. * Resident #5's - signed 04/28/16. The Facility's Denial Notice must be provided, in writing, to the the beneficiary or his/her representative in advance (2 days); and is used to inform the beneficiary or his/her representative that 1) Medicare A will not pay, 2) their right to have a claim submitted to Medicare, and 3) advises them of their appeal rights. * Resident #7's Denial Notice stated, in part, "On _____, we reviewed your medical information and found that the services furnished to [resident's name] no longer qualified as covered under Medicare beginning 2/5/16." The facility representative's signature and the resident's guardian's signature contained the date of 02/19/16 (14 days after Medicare ended, rather than 2 days before). During an interview on the afternoon of 05/19/16, a staff member (#5) stated staff members responsible for completing the notices must not be aware of the correct QIO name and toll free telephone number; and verified Resident #7's Denial Notice signed and dated 02/19/16 was not	F 156	number. 3) System change: A Medicare A tracking form has been started to track: Medicare A residents' Last Covered Day, date Facility's Denial Notice was given and signed by resident or POA, and if requested the results of demand bill. The Business Office Manager and Social Worker were educated on 5-25-2016 on the procedure titled, "Medicare Part A Non-Coverage Notification", with a focus on the QIO's new name, toll free number, and text number. 4) An audit will be developed to monitor the Medicare A discharge notice with the new tracking log to ensure residents receive notice of Medicare A discharge with the correct QIO name "KEPRO", toll free number, and text number and for the correct timing of the notice with the residents/POA signature date. The Administrator, or designee, will complete the audit weekly X 4 weeks, then monthly X 2 months. A summary report will be provided to the monthly QA committee for further recommendations for monitoring to ensure compliance.	

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F 156	Continued From page 6 timely.	F 156		
F 167 SS=B	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 the most recent Life Safety Code survey results were available for examination by residents/resident representatives on 2 of 2 days (May 16-17, 2016) the binder containing the Health and Life Safety Code surveys was observed. Failure to ensure the results of the survey, including the facility's plan of correction, are readily accessible and available to residents is an infringement of their rights. Findings include: - Observation on May 16-17, 2016 showed a binder contained the most recent Health survey results, but failed to contain the results of the Life Safety Code survey, conducted on 02/24/16. During an interview on 05/17/16 at 2:29 p.m., an	F 167	1) The Life Safety survey from 2-24-2016 and deficiency free Post-Certification revisit reports was made readily available to residents for examination and posted on 5/18/16. 2) All residents have the potential to be affected in this area. 3) An all staff education was held on 5/15/16 to educate staff on the regulation “Right to survey results” and the need for results to be available for examination with a focus on the need for staff to post the most current Life Safety survey results in a spot that is readily available to residents. 4) An audit will be developed to monitor the availability to residents and posting of	6/23/16

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F 167	Continued From page 7 administrative staff member (#1) confirmed the binder did not contain the results of the Life Safety Code survey.	F 167	the most current Federal and state surveys including life safety and annual health inspections. . The audit will be completed by the administrator, or designee, weekly X 2 weeks, then monthly X 2 months. A report summary of the audits will be provided monthly to the QA committee for further recommendations and compliance in this area.	
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: CALL LIGHTS 1. Based on record review, resident interview, group interview, facility policy/procedure review, and staff interview, the facility failed to provide reasonable accommodations of individual needs, in regard to responding to call lights in a timely manner, for 7 of 11 interviewable residents (Resident #4, A, B, C, D, E, F, and G). Failure to answer call lights in a timely manner may result in the loss of dignity and poor quality of care (i.e. falls and incontinence episodes) for all the residents who reside in the facility.	F 246	Part 1: Call lights 1) Resident #4 (and additional residents “A, B, C, D, E, F, and G”) will have response to call light in a timely manner. 2) All residents have the potential to be affected in this area. By educating our staff and conducting audit to monitor compliance will ensure timely answering of call lights. 3) An all staff was held on 6-15-2016 to educate staff on the procedure titled, “Call	6/23/16

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F 246	Continued From page 8 Findings include: Review of the facility's policy titled "Call Light" occurred on 05/19/16. This policy, issued 09/2012, stated, "PURPOSE . . . To promptly answer resident's call light. PROCEDURE. 1. When resident's call light is observed / heard, go to the resident's room promptly. 2. Respond to request as soon as possible. . . ." GROUP INTERVIEW AND RESIDENT COUNCIL MEETING MINUTES - Upon surveyor request, a facility staff member invited interviewable residents to attend the group interview. On 05/16/16 at 3:30 p.m., 4 of 7 residents in the group voiced concerns about the call lights not being answered in a timely manner. Residents' confidential comments included the following: * Resident B - "I often wait 20-25 minutes and at times the staff will ask if I can wait a few minutes more as they have two people on the stool. So it can take another half hour [for assistance]." The resident stated on one occasion the kitchen sent the resident's breakfast tray to the nurses' station as the staff did not get the resident's care done in time to eat in the dining room. The resident added staff reheated the food in the microwave, which the resident was not happy about as "food does not taste as good once it is microwaved." * Resident D - "I have waited 20-30 minutes for staff to answer." * Resident E - "I have waited up to a half hour. They are slow." * Resident F - "I feel they are short staffed."	F 246	Lights" with a focus on the need for staff to answer Call-Lights promptly and the potential for poor resident quality of care outcomes due to the risk to residents dignity and safety. 4) An audit will be developed to monitor the length of time it takes for a staff member to answer a resident's call light as well as provide care to the resident. The DNS, or designee, will be responsible to complete the audit which will include monitoring the amount of time it takes staff to answering call lights. The audits will include monitoring call light response times by running a call light report weekly X 4 weeks, then monthly for 2 months. A summary report will be provided to the monthly QA committee for further recommendations and monitoring to ensure compliance. Part 2 Wheel chair positioning 1. Resident #5 expired 5-24-2016. 2. All residents in wheelchairs have the potential to be affected in this area. 3. Education was provided on 6-15-2016 to educate nursing on the procedure titled, "Mobility Support and Positioning" with a focus on proper resident wheelchair positioning. 4. An audit will be developed to monitor residents' wheel chair positioning with a	

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F 246	Continued From page 9 Review of the Resident Council meeting minutes occurred on 05/16/16. The minutes, dated 03/07/16, stated, ". . . Nursing: . . . [Staff name] asked if the call lights were being answered in a more timely matter [sic]. Some of the residents stated that it still seems long. . . ." RESIDENT INTERVIEWS - During a confidential interview, Resident G stated she put her call light on because she needed to use the bed pan. She stated she waited "just over an hour" for staff to answer her light, and experienced bowel incontinence because of it. The resident identified another instance she waited 45 minutes for staff to answer her call light. The resident identified it was "during a meal, lunch." A final instance occurred when Resident G was still in bed at 10:00 a.m. The resident identified she does not like to be in bed that late, and had put her call light on for assistance to get up earlier in the morning. The resident stated a staff member entered her room, turned off her call light, and told Resident G she had two other lights to answer and was then going on her break. Resident G identified the staff person did not come back to assist her. Review of Resident G's medical record occurred on May 16-19, 2016. The current Omnibus Budget Reconciliation Act (OBRA) Minimum Data Set (MDS) for Resident G identified intact cognition, clear speech, able to make self understood, and able to understand others. - Review of Resident #4's medical record occurred on May 16-19, 2016. The current OBRA	F 246	focus on positioning to prevent residents from leaning too far forward in the wheelchair making them a risk for falling out. The DNS, or designee, will be responsible to complete the audit which will include random observations of residents in wheelchairs weekly X 4 weeks, then monthly X 2 months. A summary report will be provided to the monthly QA committee for further recommendations and monitoring to ensure compliance.	

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MDS for Resident #4 identified intact cognition, clear speech, able to make self understood, and able to understand others. Resident #4's progress notes identified the following:

* 04/16/16 at 9:00 a.m. - Late Entry - "Resident found on floor laying on his right side . . . Resident said he hit is [sic] head and nose is bleeding. Put cool cloth on forehead and bridge of nose was pinched to stop bleeding . . . Writer informed him just to stay still and 911 would be called. Vs [vitals] taken and resident's face was cleaned. Resident was alert, skin warm and dry. Resident was sitting in his chair before the fall . . ."

* 04/16/16 at 11:22 a.m. - Late Entry - "Sent to [name of hospital]" 04/16/16 9:22 a.m."

* 04/16/16 at 3:52 p.m. - "hospital called and informed me of . . . displaced rib fractures on the left side."

* 04/16/16 at 4:00 p.m. - Late Entry - Return from hospital - "Resident was alert, skin warm and dry. Resident's [sic] has a purple area in the skin around the left eye . . ."

During an interview on 05/18/16 at 5:25 p.m., Resident #4 explained the above-stated fall. Resident #4 stated, "I was sitting in my [recliner] chair . . . I was waiting for [staff] assistance and I waited for over 20 minutes . . . no one came . . . so I decided I could do it myself [pull up pants] and I fell."

- During a confidential interview on the afternoon of 05/16/16, Resident C stated it can take "up to an hour sometimes" before staff answer his/her call light. "This morning it was 45 minutes." The resident stated within the last week, waiting for staff to answer his/her call light resulted in

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incontinence of bladder. "I wet the chair."

Review of Resident C's medical record occurred on May 16-19, 2016. The current OBRA MDS for Resident C identified intact cognition, clear speech, able to make self understood, and able to understand others. Review of his/her recent toileting records showed Resident C experienced occasional episodes of bladder incontinence.

- During a confidential interview on the afternoon of 05/17/16, Resident A stated "is sometimes a half hour or longer" before his/her call light is answered. Resident A stated waiting a long time for the call light to be answered resulted in incidents of bladder incontinence.

Review of Resident A's medical record occurred on May 16-19, 2016. The current OBRA MDS for Resident A identified intact cognition, clear speech, able to make self understood, and able to understand others. Review of his/her recent toileting records showed Resident A experienced occasional episodes of bladder incontinence.

STAFF INTERVIEWS

- During the survey, an anonymous staff member (A) stated regarding staff answering call lights, "Sometimes staff do not return to the resident's room when they say they are going to." This staff member did not know why the staff fail to return, stating maybe "they forgot or were too busy."

- During the survey, an anonymous staff person (B) voiced concerns regarding call lights. The staff member identified staff are not answering lights, they enter residents' rooms and turn off the

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F 246	Continued From page 12 lights but do not provide care. - During the survey, an anonymous staff person (C) voiced concerns regarding insufficient and inadequate staffing; resulting in some residents experiencing falls, not receiving cares in a timely manner, and/or not receiving cares according to acceptable standards of practice. - During the survey, an anonymous staff person (D) voiced concerns regarding insufficient and inadequate staffing; resulting in some residents experiencing falls and/or not receiving cares in a timely manner. WHEELCHAIR POSITIONING 2. Based on observation, review of facility policy, record review, and staff interview, the facility failed to provide reasonable accommodation of individual needs regarding wheelchair positioning for 1 of 8 sampled residents observed in a wheelchair (Resident #5). Failure to provide proper wheelchair positioning may result in falls, discomfort, contractures, and loss of mobility. Findings include: Review of the facility policy titled "Mobility Support and Positioning: Positioning" occurred on 05/19/16. This policy, revised May 2016, stated, ". . . Wheelchair Position . . . Feet rest flat on a support . . . When the individual leans forward in the chair, his or her nipple line should not fall in front of the seat edge (outside the base of support). . . . Gravity assisted seating can be achieved by placing the rear wheel in the top axel [sic] position and the front caster in the lowest	F 246		

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position to achieve a seat tilted to the rear and eliminating the need for a seat belt or other restraining device. . . . Therapists can assist with adaptive equipment and wheelchair selection if there is difficulty correctly positioning the resident. . . ."

Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, history of a clavicle fracture, arthropathy (joint disease), muscle weakness, and a history of falls. The resident's current care plan identified, ". . . does not ambulate, w/c [wheelchair] primary mode of transportation . . . at risk for falls r/t [related to] Unaware of safety needs, dx [diagnosis of] dementia, arthritis, edema, decreased rom [range of motion] to right shoulder, and takes antidepressant, antianxiety, and antipsychotic medication . . . Monitor resident for significant changes in gait, mobility, positioning device, standing/sitting balance, and lower extremity joint function . . ."

A nurses' notes identified the following:
*03/18/16 at 5:52 p.m.: ". . . Resident had been agitated starting about 4 p.m., she was crying, demanding to go home . . . She wheeled herself away from where this staff was, as she was wheeling she yelled out I am going to fall, . . . she used her head in a downward motion and put her arms out without standing, rolling onto the ground . . ."
*03/19/16 at 9:20 a.m.: ". . . up in w/c in east lounge. Medaide [medication aide] witnessed her roll herself out of her w/c on to the floor. . . ."
*04/25/16 at 7:55 p.m.: ". . . Res [resident] was sitting in w/c and leaned forward landing on the floor on forehead. Lifted off floor using Hoyer [a

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F 246	Continued From page 14 full body mechanical lift] and placed into bed. Res reports headache. . . ." *04/26/16 at 3:21 p.m.: ". . . Resident has not had any behaviors today but does lean down in w/c. . . ." *04/26/16 at 10:13 p.m.: ". . . W/C for locomotion with staff assist to reach destinations. Repositioned in chair due to resident leaning to side or forward. . . ." *04/28/16 at 2:53 a.m.: ". . . Has been leaning to sides or forward in w/c and needs redirection and repositioning. Has not attempted self-transfers. Non-ambulatory and does not self-propel w/c. Needs staff assist to reach destinations. . . ." *04/29/16 at 4:00 p.m.: ". . . Resident is very tired today, sleeping in her chair, placed her in her bed x2 [twice], but she attempts to climb out. . . . She is nearly 1:1 [one to one] when in her chair, she was touching the floor, taking off her shoes when she was moving. . . ." *04/30/16 at 2:53 p.m.: ". . . Resident continues to exhibit behavior of leaning over while in wheelchair, nearly to the point of tipping over while in the wheelchair. . . . Resident is often leaning over asleep in the wheelchair throughout most of the day . . . This nurse has spent 1:1 time with this Resident when possible to decrease risk for fall due to Resident's lethargy however this nurse will follow up with facility staff concerning safety risk due to sedation and fall risk. . . ." *04/30/16 at 7:04 p.m.: ". . . Became fatigue [sic] this afternoon, leaning forward in her w/c, assisted to bed . . ." A "Falls Tool," dated 04/26/16, identified Resident #5 at "high risk" for falls, and an "Action Plan" which stated, "Refer to therapy."	F 246		

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During an interview on 05/19/16 at 12:58 p.m., a therapy staff member (#12) stated they did not receive a referral after Resident #5's fall on 04/25/16. During an interview on 05/19/16 at 2:24 p.m., a supervisory nurse (#7) confirmed physical therapy staff did not pick up Resident #5 as a patient.

Observation on 05/17/16 at 7:56 a.m. showed a two certified nursing assistants (CNAs) (#8 and #9) assisted Resident #5 out of bed and into her wheelchair. Observation showed the resident leaned forward and to her left side. The CNA (#8) stated, "Not sure if I should leave her up. I don't want her to fall." The CNA called a licensed nurse (#10) into the room. The nurse instructed the CNAs to transfer the resident back to bed. The nurse stated Resident #5 is a "huge fall risk," and she might fall from her wheelchair if she is sleepy.

Observation on 05/17/16 at 11:24 a.m. showed two CNAs (#8 and #11) assisted Resident #5 out of bed and into her wheelchair. The resident's feet/lower legs did not rest on the foot pedals, instead resting between and slightly behind the foot pedals.

Observation on 05/18/16 at 8:36 a.m. showed two CNAs (#8 and #9) assisted Resident #5 out of bed and into her wheelchair. The resident again leaned to the left side, and her feet/lower legs did not rest on the foot pedals. The CNA (#8) commented, "We need one of those things [a foot board] to put behind her because her legs never stay." The CNA also identified staff are instructed to put Resident #5 back in bed if she is leaning forward because she is a fall risk.

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F 246	Continued From page 16 Failure to ensure proper wheelchair positioning limited Resident #5's mobility and participation in meals/activities and may have contributed to falls from her wheelchair.	F 246		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to complete a Quarterly Minimum Data Set (MDS) for 1 of 9 sampled residents (Resident #4) within 92 days after the Assessment Reference Date (ARD) of the previous Omnibus Budget Reconciliation Act (OBRA) assessment. Failure to complete quarterly assessments in a timely manner, delays the facility in obtaining the assessment information necessary to revise a care plan and to provide the appropriate care and services for the residents. Findings include: The Long-Term Care Facility RAI User's Manual, October 2015, Chapter 2, page 31, stated, "The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days	F 276	1) Resident #4 individual needs have been met on 5/17/2016 a quarterly MDS assessment was completed and was accepted by CMS on 5/23/2016. 2) All residents have the potential to be affected. All current residents will have their MDS schedules reviewed for the past 3 months. If a missing MDS assessment is identified immediate action will be taken including opening the missed MDS, complete it, and submitted it to CMS. 3) Education will be provided on 6-15-2016 by the Clinical Rehab Consultant from Good Samaritan Society National Campus with a focus on the need for timely completion of quarterly OBRA MDS assessments and the use of the GSS #278 MDS and Care plan notification schedule. Focus education	6/23/16

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F 276	Continued From page 17 following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. . . . The ARD must be within 92 days after the ARD of the previous OBRA assessment . . ." - Review of Resident #4's MDSs occurred on May 16-17, 2016. Resident #4's Significant Change in Status Assessment (SCSA) showed an ARD of 02/05/16. MDS review showed no OBRA MDS in progress or completed after the SCSA, thus exceeded the 92 days after the ARD of the previous OBRA assessment. During an interview on the morning of 05/17/16, a nursing staff member (#6) confirmed a quarterly MDS should have been completed within 92 days after the ARD of the previous OBRA SCSA dated 02/05/16.	F 276	from the RAI manual on page 31, stating "The quarterly MDS assessment is an OBRA non-comprehensive assessment for a resident and must be completed at least every 92 days following the previous OBRA assessment of any type. System change: Implementation of GSS #278 for the MDS and care plan notification of scheduled dates. 4) An audit will be developed to monitor the MDS schedule for compliance with Quarterly MDS assessments. The audit will be completed by the Administrator, or designee, and will monitor the MDS schedule weekly X 4 weeks, then month X 2 months. A summary report will be provided to the monthly QA committee for further recommendations for monitoring to ensure compliance.	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		6/23/16

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F 278	Continued From page 18 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the resident's status for 4 of 9 sampled residents (Resident #1, #4, #6, and #8). Failure to accurately code shortness of breath and/or determination of pressure ulcer risks does not allow the residents' assessments to reflect their current status/needs; and has the potential to affect the accurate development of a comprehensive care plan and the care provided to these residents. Findings include: SHORTNESS OF BREATH The Long-Term Care Facility RAI User's Manual, revised October 2015, Chapter 3 page J-20 -	F 278	1) The MDS for Resident #1, #4, #6 and #8 were reviewed and corrected the sections involving the coding of SOB and skin risk assessment and were resubmitted on 6-16-2016. 2) All residents who were coded on an MDS in the past 3 months for shortness of breath and coded for having a completed assessment for skin and pressure ulcers skin break down risk have the potential to be affected. A list of resident coded in each of these sections will be generated and reviewed to ensure supportive documentation is in place for coding the MDS for SOB and risk assessment for skin breakdown and pressure ulcers. If unable to provide supportive documentation the MDS coding will be corrected, and resubmitted to CMS.	

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F 278	Continued From page 19 J-21 stated, ". . . J1100: Shortness of Breath (dyspnea) . . . Check all that apply during the 7-day look-back period. Any evidence of the presence of a symptom of shortness of breath should be captured in this item. A resident may have any combination of these symptoms. . . . Check J1100C: if shortness of breath or trouble breathing is present when the resident attempts to lie flat. Also code this as present if the resident avoids lying flat because of shortness of breath . . ." - Review of Resident #1's medical record occurred on May 16-19, 2016. The admission MDS, dated 12/16/15, identified Resident #1 experienced shortness of breath or trouble breathing when lying flat (item J1100C checked). The facility failed to code Resident #1's MDS accurately for item J1100C, as the medical record lacked evidence this resident experienced shortness of breath or trouble breathing when lying flat during the look-back period (December 10, 2015 - December 16, 2015). - Review of Resident #4's medical record occurred on May 16-19, 2016. The significant change in status assessment (SCSA), dated 02/05/16, identified Resident #4 experienced shortness of breath or trouble breathing when lying flat (item J1100C checked). The facility failed to code Resident #4's MDS accurately for item J1100C, as the medical record lacked evidence this resident experienced shortness of breath or trouble breathing when lying flat during the look-back period (January 30, 2016 - February 5, 2016).	F 278	3) Education was provided to the DNS and MDS coordinator on 6-15-2016 from the Clinical Rehab Consultant from Good Samaritan Society on the coding instructions for J1100C and M 0100B from the RAI manual Chapter 3 pages J-20 and J-21 which provide the coding instructions for shortness of breath and formal pressure ulcer risk assessment. 4) An audit will be created to monitor the coding of MDS sections J1100C and M 0100B. The audit will be completed by the DNS, or designee, weekly X 4 weeks, then monthly X 2 months. A summary report will be provided to the monthly QA committee for further recommendations for monitoring to ensure compliance.	

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F 278	Continued From page 20 - Review of Resident #8's medical record occurred on May 18-19, 2016. The quarterly MDS, dated 01/22/16, identified Resident #8 experienced shortness of breath or trouble breathing when lying flat (item J1100C checked). The facility failed to code Resident #8's MDS accurately for item J1100C, as the medical record lacked evidence this resident experienced shortness of breath or trouble breathing when lying flat during the look-back period (January 16, 2016 - January 22, 2016). DETERMINATION OF PRESSURE ULCER RISK The Long-Term Care Facility RAI User's Manual, revised October 2015, Chapter 3 page M-2 - M-3 stated, ". . . Check B if a formal assessment has been completed. An example of an established pressure ulcer risk tool is the Braden Scale for Predicting Pressure Sore Risk. Other tools may be used. Check C if the resident's risk for pressure ulcer development is based on clinical assessment. A clinical assessment could include a head-to-toe physical examination of the skin and observation or medical record review of pressure ulcer risk factors. . . ." - Review of Resident #4's medical record occurred on May 16-19, 2016. The significant change in status assessment (SCSA), dated 02/05/16, identified the resident's risk for pressure ulcer development was based on a formal assessment (item M0100B checked). The facility failed to code Resident #4's MDS	F 278		

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F 278	Continued From page 21 accurately for items M0100B, as the medical record lacked evidence of a formal pressure ulcer risk assessment being completed during the look-back period (January 30, 2016 - February 5, 2016). - Review of Resident #6's medical record occurred on May 16-19, 2016. The quarterly MDS, dated 02/12/16, identified the resident's risk for pressure ulcer development was based on a formal assessment (item M0100B checked). The facility failed to code Resident #6's MDS accurately for items M0100B, as the medical record lacked evidence of a formal pressure ulcer risk assessment being completed during the look-back period (February 6, 2016 - February 12, 2016). During interview on the morning and the afternoon of 05/17/16, and on the morning of 05/19/16, a nurse staff member (#6) confirmed the facility had incorrectly coded shortness of breath and formal (pressure ulcer) assessments as stated above.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: INSULIN ADMINISTRATION 1. Based on observation, review of professional reference, and staff interview, the facility failed to	F 281	Part 1 Insulin Administration 1) Resident #8 and #9 are receiving their meal or 4 oz. of juice and a cracker	6/23/16

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F 281	Continued From page 22 follow professional standards of practice regarding insulin administration for 2 of 4 sampled residents observed receiving rapid-acting insulin (Resident #8 and #9). Failure to ensure food is offered within the recommended time frame after insulin administration may result in hypoglycemia (low blood sugar). Findings include: The "Nursing 2015 Drug Handbook," 35th Edition, Wolters Kluwer, Pennsylvania, Page 759-760, stated, ". . . NovoLog . . . Give NovoLog 5 to 10 minutes before start of meal. . . ." - Observation on 05/17/16 at 4:52 p.m. showed a nursing staff member (#10) administered 29 units of NovoLog insulin to Resident #8. Observation showed Resident #8 did not receive her meal tray until 5:29 p.m. (37 minutes later). - Observation on 05/18/16 at 4:59 p.m. showed a nursing staff member (#13) administered 12 units of NovoLog insulin to Resident #9. Observation showed Resident #9 did not receive her meal tray until 5:27 p.m. (28 minutes later). During an interview on 05/19/16 at 10:50 a.m., a supervisory nurse (#4) stated staff are expected to give juice with insulin administration if they do not administer the insulin with a meal. NEUROLOGICAL ASSESSMENTS 2. Based on record review, review of facility policy/procedure, and staff interview, the facility failed to provide care in accordance with	F 281	after the nurse administered their physician ordered short acting insulin “Novolog”. 2) All residents who receive short-acting insulin have the potential to be at risk. A list of resident that receive short acting “Novolog” insulin will be generated and use for audit monitoring for compliance. 3) A mandatory nursing meeting was held on 6/15/16 to education the staff on the procedure titled, “Insulin administration” with a focus on the need for licensed nurse to provide a meal or 4 oz. of juice and a cracker, within 5-15 minutes of receiving short acting “Novolog” insulin. 4) An audit will be developed to monitor the length of time after a resident receives short acting, “novolog” insulin and the time the resident eats their meal or receives 4 oz. of juice and a cracker within 5-15 minutes. The audit will be completed by the DNS, or designee, 1 X per week X 4 weeks, then monthly X 2 months. A summary report will be provided to the monthly QA committee for further recommendations for monitoring to ensure compliance. F 281 Part 2 Neurological Assessments 1. Resident #4 has no permanent change in neurological assessment and has returned to baseline. Care plan reviewed and updated as needed	

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F 281	Continued From page 23 professional standards for 1 of 3 sampled residents (Resident #4) who experienced a recent fall resulting in a head injury. Failure to complete neurological evaluations following such a fall has the potential for head injury complications to go undetected. Findings include: Review of the facility policy/procedure titled "Neurological Evaluation" occurred on 05/19/16. This policy, issued September 2012, stated ". . . PURPOSE: To establish a baseline neurological status upon which subsequent evaluations may be compared and changes in neurological status may be determined. USE: Following a witnessed fall when a resident has hit his/her head. Following an unwitnessed fall. Following a resident event that results in a known or suspected head injury (e.g., hemorrhagic stroke) . . . Initiate and document a baseline neurological evaluation on the Neuro-Check UDA . . . After the completion of initial neurological evaluation with vital signs, continue with evaluations every 30 minutes x 4, then every shift x 3 days OR: as appropriate or more frequently as directed by the physician . . ." - Review of Resident #4's medical record occurred on May 16-19, 2016. Resident #4's progress notes identified the following: * 04/16/16 at 9:00 a.m. - Late Entry - "Resident found on floor laying on his right side . . . Resident said he hit is [sic] head and nose is bleeding. Put cool cloth on forehead and bridge of nose was pinched to stop bleeding . . . Writer informed him just to stay still and 911 would be called. Vs [vitals] taken and resident's face was	F 281	2. Neuro checks will be done on all residents with falls with potential head injury 3. A nursing meeting was held on 6-15-2016 to educate the staff on the procedure titled, “Neurological Evaluation” with a focus on the need to establish baseline neurological status upon which subsequent evaluations may be compared and changes in neurological status may be determined. Neuro-Check UDA needs to be completed every 30 min. X 4, then every shift X 3 days OR as appropriate or more frequently as directed by the physician. 4. An audit will be developed to monitor residents that fall and hit their head ensuring that neurological checks are completed on the neuro-check UDA according to procedure. The audit will be completed by the DNS, or designee, weekly X 4, then monthly X 2 month. A summary report will be provided to the monthly QA committee for further recommendations for monitoring to ensure compliance.	

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F 281	Continued From page 24 cleaned. Resident was alert, skin warm and dry. Resident was sitting in his chair before the fall . . ." * 04/16/16 at 11:22 a.m. - Late Entry - "Sent to [name of hospital]" 04/16/16 9:22 a.m. * 04/16/16 at 3:52 p.m. - "hospital called and informed me of . . . displaced rib fractures on the left side." * 04/16/16 at 4:00 p.m. - Late Entry - Return from hospital - "Resident was alert, skin warm and dry. Resident's [sic] has a purple area in the skin around the left eye. Resident has a clear fluid emesis when he returned . . ." * 04/16/2016 at 10:00 p.m. - ". . . Contusion to Lt [left] eye . . ." Review of Resident #4's medical record showed no initial neurological evaluation completed after he sustained a head injury on the morning of 04/16/16, and showed no neurological checks upon his return from the hospital emergency room on the afternoon of 04/16/16. The medical record identified two neurological evaluations. The first neuro evaluation by facility staff occurred on 04/18/16 at 11:30 a.m. (approximately 50 hours after the head injury), and the second neuro evaluation by facility staff occurred on 04/19/16 at 6:30 p.m. (approximately 74 hours after the head injury). During an interview on the afternoon of 05/18/16, a consulting nurse (#7) stated she would expect nursing staff members to complete neurological evaluations as per facility policy.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		6/23/16

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F 309	Continued From page 25 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/22/15. Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to manage behavioral and psychological symptoms of dementia (BPSD) for 2 of 3 sampled residents (Resident #2 and #5) identified with behaviors who received as needed (PRN) psychoactive medications. Failure to thoroughly assess the residents' behaviors in an attempt to determine causative factors and implement individualized non-pharmacological interventions prior to administration of PRN psychoactive medications may result in decreased well-being and negatively impact the residents' quality of life. Findings include: Review of the facility policy titled "Psychopharmacological Medications and Sedative/Hypnotics" occurred on 05/19/16. This policy, revised March 2015, stated, ". . . While the use of prn psychopharmacological medications and sedative/hypnotics is not encouraged, if a prn physician's order is received, ensure that the order has clear	F 309	See also F 329 1) Resident # 2 individual needs have been met by updating the physician order for Psychoactive Medication to include additional documentation required by the licensed nurse to document on the e-mar that non-medications interventions have been provide before administering PRN psychoactive medications. The license nurse will document the behavior and staff non-medication interventions attempted prior to the administration of as needed (PRN) psychoactive medications. Resident #5 has expired 5-24-2016. 2) All residents receiving PRN psychoactive medications have the potential to be affected in this area. A list of resident currently receiving as needed (PRN) antipsychotic medications will be generated and each resident physicians orders will be reviewed to ensure the residents have attempted for non-medication interventions prior to administering the as needed (PRN) antipsychotic medication.	

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F 309	Continued From page 26 parameters . . . It is important to initiate other care plan interventions prior to the use of prn psychopharmacological medications and sedative/hypnotics. . . ." Review of the facility policy titled "Psychopharmacological Medications and Sedative/Hypnotics" occurred on 05/19/16. This policy, revised August 2014, stated, ". . . PURPOSE: To evaluate behavior interventions and alternatives before using psychopharmacological medications and sedative/hypnotics . . . Behavioral Interventions: Individualized non-pharmacological approaches that are provided as part of a supportive physical and psychosocial environment and are directed toward preventing, relieving, and/or accommodating a resident's distressed behavior . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, depression, anxiety, and a history of a hip fracture (02/01/16). The resident's current care plan stated, ". . . behavior symptom . . . E/B [evidenced by] forgetting she ate meals, dislikes snug fitting clothes at her waist and is easily agitated. Aggressive/weepy with ADL's [activities of daily living], mobility & tub bath, will repeat clearing her throat & spit. . . . Attempt non-pharmacological interventions such as redirection, 1:1 visits, go for a walk with resident (if weather outside is nice), offer warm blanket. May call niece . . . Reapproach resident at a later time or have another staff try to assist. Allow her to awaken on her own in the am [morning] then initiate am cares. Keep Kleenex at hand for her to spit in. . . .	F 309	3) All nursing staff meeting held on 6/15/16 to educate staff on the procedure titled, “Psychopharmacological Medications and Sedatives/Hypnotics”, with a focus on the need for staff to attempt approximately three non-pharmacological interventions prior to the license nurse administering a PRN antipsychotics. Education include the nurse must document a progress note of the residents behavior and what non medication interventions staff attempted prior to administration or a PRN antipsychotic medications, and the results of the medication effectiveness. 4) An audit will be developed to monitor the behavior progress notes for documentation of the behavior and the non- medication interventions the staff attempted before the administration of a PRN antipsychotic, and the effectiveness of the medication. The DNS, or designee, will be responsible for the completion of the audit. The audit will be completed 1per week X 4 weeks, then monthly X 2 months. A summary report will be provided to the monthly QA committee for further recommendations for monitoring to ensure compliance.	

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F 309	Continued From page 27	F 309		

Visit with resident about past and her children/grandchildren. Try to involve in an activity that is low stim. [stimulation] Ask simple questions to help determine cause of agitation such as BR [bathroom] needs, hunger, hot or cold, & address as appropriate. Use one word commands. . . ."

Physician's orders included:
* 08/31/15: Seroquel (an antipsychotic) 25 milligrams (mg) daily as needed (prn) (discontinued 03/14/16).
* 02/28/16: Lorazepam (Ativan, an anxiolytic) 2 mg intramuscularly (IM) every eight hours PRN for behaviors. Can give 2 mg liquid Ativan in place of IM injection.
* 03/15/16: Attempt non-pharmacological interventions prior to the use of PRN meds (medications) for mood & behavior. Document what attempts made & effectiveness.

Resident #2's nurses' notes identified the following:
* 02/16/16 at 1:26 p.m.: ". . . Resident was seen today by [psychiatric doctor]. . . Reviewed recent fall and hip surgery d/t [due to] left hip fx [fracture]. Resident continues to be combative, hitting and kicking out at staff during cares. Unsure if resident is having pain related to hip or increased agitation. . . ."
* 02/16/16 at 6:59 p.m.: ". . . Seroquel Tablet 25 mg . . . resident combative with staff, trying to rip her clothes off, and yelling at staff. Tried to redirect resident and resident kept yelling at staff and pulling on clothes. . . ."
* 02/17/16 at 1:50 p.m.: ". . . Seroquel Tablet 25 mg . . . patient threw her blanket on the floor, pulling on her pants, increased agitation even

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F 309	Continued From page 28 after Oxycodone PRN . . ." * 02/18/16 at 8:44 a.m.: ". . . Seroquel Tablet 25 mg . . . resident yelling at staff, resident crying repeatedly trying to stand up and get out of bathtub. Staff attempted to redirect resident with no success. . . ." * 02/19/16 at 10:36 a.m.: ". . . Seroquel Tablet given for anxiety, hitting out with cares, reassurance did not ease her. . . ." * 02/20/16 at 9:32 a.m.: ". . . Seroquel Tablet 25 mg . . . resident crying and unable to console. . . ." * 02/21/16 at 10:29 a.m.: ". . . Seroquel Tablet 25 mg . . .resident trying to stand up and walk, resident taking clothes and underwear off. Resident crying uncontrollably. . . ." * 02/27/16 at 9:01 a.m.: ". . . resident kicking and yelling at staff, resident is also trying to bite staff. Attempted to redirect with no results. . . ." * 03/21/16 at 11:37 p.m.: ". . . Resident had a good night, No agitation noted. Does need a UA/UC [urinalysis/urine culture] and CBC [complete blood count]. resting well at this time. . . ." * 03/22/16 at 5:00 a.m.: ". . . Gave resident PRN liquid ativan [at] [4:00 a.m.] for CBC draw and UA collection. Attempted blood draw x2 [twice] to left arm and unsuccessful. Attempted cath [catheter] UA and resident was aggitated [sic] and uncooperative. . . ." * 03/25/16 at 7:58 a.m.: ". . . Lorazepam Solution 2 MG/ML [milligrams per milliliter] . . . resident inconsolable, cryinging [sic] continuously, yelling for family. Resident agitated wanting to leave facility, staff talking to resident trying to reassure resident that she lives here and that everything is ok. Resident continues to cry and yell at staff. . . ."	F 309		

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F 309	Continued From page 29 * 05/08/16 at 11:33 p.m.: ". . . Lorazepam Solution 2 MG/ML . . . Given for agitation and restless. Gave 2 mg liquid Ativan. . . ." * 05/13/16 at 1:00 a.m.: ". . . Lorazepam Solution 2 MG/ML . . . extremely agitated other interventions failed . . ." Staff failed to assess Resident #2's behaviors for possible causative factors (including unresolved pain from her hip fracture) and implement individualized non-pharmacological interventions prior to administering PRN Seroquel/Ativan. * Refer to F329 - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, depression, and anxiety. The current care plan stated, ". . . at risk for behaviors r/t [related to] Dementia, anxiety, agitation, impulsiveness. And has depression . . . Attempt non-pharmacological interventions such as warm blanket, 1:1 [one to one visits], tv/radio, and/or having the facility cat visit. . . . uses psychopharmacological medications . . . Anxiety: Attempt non-medication approaches such as distraction, 1:1 visit, offer food/snack, toilet. . . ." Physician's orders included Ativan 0.25 mg every 12 hours PRN (discontinued 03/24/16). Nurses' notes identified the following PRN administration of Ativan: * 01/20/16 at 11:40 a.m.: ". . . Resident finished Pt [physical therapy] with [PT name] & cam [sic] out of therapy & said shes shakin [sic] and cant drive the car anymore. Was taken to dinner & started to get anxious due to a male serving	F 309		

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F 309	Continued From page 30 lunch & she would not eat because he was gonna make her drive the car & she cant anymore. Was brought out to nurses station & Ativan given. . . ." * 02/11/16 at 12:30 p.m.: ". . . resident agitated and yelling out at staff, and other residents, attempted to redirect resident and she kept yelling. . . ." * 02/12/16 at 11:00 p.m.: ". . . banging on walls and yelling in room. . . ." * 02/15/16 at 8:48 a.m.: ". . . PRN dose given at tis [sic] time . . ." * 02/18/16 at 2:00 p.m.: ". . . resident anxious and crying continuously. . . ." * 02/19/16 at 2:46 a.m.: ". . . very anxious, bounding [sic] on the walls, yelling, tearing off brief and clothes. . . ." * 03/06/16 at 12:00 a.m. No nurse's note entered. * 03/09/16 at 8:15 p.m.: ". . . Restless, anxious. Shredding brief, taking clothes off. . . ." * 03/10/16 at 8:10 a.m.: ". . . Given PRN due to anxiety, tearing off clothing, been over an hour since scheduled [sic] med. She is tearful and difficult to reasure [sic]. . . ." * 03/18/16 at 6:12 a.m.: ". . . Anxiety, crying unable to calm and 2 hours til scheduled [sic] dose . . ." * 03/18/16 at 9:30 p.m.: ". . . Anxious, restless. Undressed self, shredding brief. . . ." * 03/21/16 at 1:25 a.m.: ". . . Adm [administered] for increased anxiety, restlessness. . . ." * 03/21/16 at 1:50 p.m. No nurse's note entered. Staff failed to assess Resident #5's behaviors for possible causative factors and attempt	F 309		

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F 309	Continued From page 31 individualized non-pharmacological interventions prior to administering PRN Ativan. During an interview on 05/19/16 at 8:30 a.m., a supervisory nurse (#4) stated staff are expected to document non-pharmacological interventions they attempted in a progress note.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: TOILETING PLAN 1. Based on observation, record review, and staff interview, the facility staff failed to implement a toileting plan for 1 of 3 sampled residents (Resident #6), incontinent of bladder and observed toileted. Failure to implement a toileting plan, at the times consistent with a residents' care plan, places residents at risk for increased bladder incontinence (avoidable), skin breakdown, urinary tract infections, and may compromise residents' individual dignity. Findings include:	F 315	Part 1 Toileting Plan 1) Resident #6 will have toilet pattern reviewed for an appropriate toileting schedule to prevent avoidable bladder incontinence, skin breakdown, UTI's, and may compromise the residents' individual dignity. Care plan reviewed and updated as needed. 2) All residents that are at low risk for bladder incontinence have the potential to be affected in this area. A list of residents will be generated to identify resident that	6/23/16

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F 315	Continued From page 32 Review of Resident #6's medical record occurred on May 16-19, 2016. The current quarterly Minimum Data Set (MDS) for Resident #6, dated 05/12/16, identified usually makes self understood, severely impaired cognition, occasionally incontinent of bladder, frequently incontinent of bowel, and requires extensive assistance of one person for toileting. The current care plan for Resident #6 regarding urinary incontinence stated, ". . . requires assistance with all ADL's [activities of daily living] and mobility r/t [related to] dx: [diagnosis] dementia . . ." INTERVENTION - ". . . TOILET USE: Resident requires 2 staff participation to use toilet. . . . Toileting schedule: q2 [every two] hours during the day and q4 hours at night and prn [as needed] . . ." Observations conducted on May 16-19, 2016 identified facility staff did not implement Resident #6's toileting plan as identified in the care plan. Observation of Resident #6 occurred on 05/16/16 from 2:30 p.m. to 5:30 p.m.; on 05/17/16 from 7:40 a.m. to 5:40 p.m.; on 05/18/16 from 7:30 a.m. to 5:30 p.m.; and on 05/19/16 from 7:30 a.m. to 9:30 a.m. (excluding when out of the facility for lunch). Observations during these time periods showed the following: * 05/17/16 after the noon meal - a certified nursing assistant (CNA) identified Resident #6 was going to be toileted, but the surveyor was unable to observe * 05/18/16 at 9:05 a.m. - attempted to be toileted by two staff members, resident refused * 05/18/16 at 11:00 a.m. - toileted, continent	F 315	are occasionally incontinent of bladder to determine the need for a Scheduled Toileting Program to prevent avoidable incontinence. Care plans will be updated as needed. 3) A mandatory Nursing staff held was on 6/15/16 to educate staff on the procedure titled, “Toileting Program” with a focus on the need to provide a toileting schedule for residents to prevent avoidable incontinence. 4) An audit will be developed and completed by the DNS, or designee, to audit residents that need a schedule toileting plan and are toileted according to the toileting care plan to prevent incontinence. The audit will be completed weekly X 4 weeks, then monthly X 2 months. A summary report will be provided to the monthly QA committee for further recommendations for monitoring to ensure compliance. Part 2 Urinary Tract Infection See also F 502 Laboratory Services 1. Resident #2 has been treated appropriately for the UTI and returned to baseline. Care plan updated. 2. All residents with a physician order for a urine analysis in the past 3 months will be reviewed to ensure the test results	

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F 315	Continued From page 33 and voided * 05/18/16 at 3:30 p.m. - attempted to be toileted by one staff member, resident declined * 05/19/16 at 9:05 a.m. - toileted, continent and voided Review of Resident #6's urine voiding records occurred on May 18-19, 2016. These voiding records were designed to show the date and time the resident was toileted, if continent, incontinent, if resident refused, etc. Review of Resident #6's urine voiding records, for the time period of May 1, 2016 through May 15, 2016, showed facility staff failed to toilet this resident every 2 hours during the day and every 4 hours at night. A sample of the urine voiding records for a one week period (May 8-14, 2016) are as follows: * 05/08/16 - toileted 3 times in a 24 hour period (5:55a, 12:58p, and 7:00p). * 05/09/16 - toileted at 5:35a, 6:57a, 6:58a, 10:40a, 1:41p (refused), and 11:45p. * 05/10/16 - toileted 2 times in a 24 hour period (10:10a and 10:58a). * 05/11/16 - toileted 3 times in a 24 hour period (2:21a, 1:13p, and 8:18p). * 05/12/16 - toileted 4 times in a 24 hour period (12:51a, 5:57a, 2:35p, and 7:00p). * 05/13/16 - toileted 2 times in a 24 hour period (5:44a and 12:45p). * 05/14/16 - toileted 2 times in a 24 hour period (2:38a and 1:16p). Review of the urine voiding records identified documentation often lacked whether Resident #6 was continent or incontinent when toileted. Facility staff failed to implement a consistent	F 315	have been received and the physician was notify of any positive test results. 3. A mandatory Nursing staff held was on 6/15/16 to educate staff on the procedure titled, “Laboratory Services” with a focus on the need to ensure prompt diagnosis and treatment of a UTI to prevent unnecessary discomfort, kidney infections, and/or sepsis. 4. An audit will be developed and completed by the DNS, or designee, to audit residents with a positive urine analysis to ensure timely notification and treatment of UTI’s. The audit will be completed weekly X 4 weeks, then monthly X 2 months. A summary report will be provided to the monthly QA committee for further recommendations for monitoring to ensure compliance.	

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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 315	Continued From page 34 toileting schedule for Resident #6 to enable this resident to maintain her highest level of bladder continence. URINARY TRACT INFECTION 2. Based on record review, review of facility policy/procedure, and staff interview, the facility failed to provide timely services for 1 of 2 sampled residents (Resident #2) with a history of urinary tract infections (UTIs). Failure to ensure prompt diagnosis and treatment of a UTI may result in unnecessary discomfort, a kidney infection, and/or sepsis. Findings include: - For evidence the facility failed to ensure prompt diagnosis and treatment of a UTI for Resident #2, refer to F502, Laboratory Services.	F 315		
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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/22/15. Based on observation, record review, and staff	F 323	1) Resident #2 will be reassessed using the mobilization date collection tool and staff will transfer the resident according to their Care Plan.	6/23/16

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F 323	Continued From page 35 interview, the facility failed to ensure appropriate use of devices to prevent accidents for 2 of 6 sampled residents (Resident #2 and #5) who required extensive assistance with transfers. Failure to clearly identify how staff are expected to transfer residents and failure to complete transfers according to the care plan placed these residents at risk for falls, pain, and injury. Findings include: - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia, epilepsy, arthropathy (joint disease), and a history of falls. The resident's current Minimum Data Set (MDS), dated 05/04/16, identified extensive assistance from two or more people for transfers. The current care plan stated, ". . . TRANSFER: Assist 2 . . . Mechanical lift as indicated . . ." Observation on 05/17/16 at 8:50 a.m. showed a certified nursing assistant (CNA) (#8) assisted Resident #2 to sit up in bed and placed a gait belt around her waist. She attempted to assist the resident to stand, but the resident was unable to do so. The CNA asked another CNA in the hallway how Resident #2 currently transfers. The other CNA responded, "Two people, if she's tired we can use a lift." The CNA (#8) stated, "She changes all the time. Sometimes she's a maxi [full body mechanical lift], sometimes she's a stand [sit-to-stand mechanical lift]..." She then called for assistance. Another CNA (#9) entered the room and assisted with a pivot transfer from the bed to the wheelchair. The two CNAs then pivoted Resident #2 from the wheelchair to the toilet. One CNA (#9) left the room, and the other	F 323	Resident #5 has expired 5-24-2016. 2) All residents requiring the need for staff assistance with a transfer have the potential to be affected in this area. A list of residents that need staff assistance with transfers will generate and care plan updated for transfer assistance. 3) A mandatory nursing staff was held on 6-15-2016 to educated staff on the Safe Resident Handling Program will a focus on the need for consistent terminology in care plans and ensures residents are transferred according to their mobilization data collection UDA and as care planned. 4) An audit will be developed to monitor if the resident transferred according to their assessment and care plan. The DNS, or designee, will be responsible for the completion of the audit. The audit will be completed weekly X 4 weeks, then monthly X 2 months. A summary report will be provided to the monthly QA committee for further recommendations for monitoring to ensure compliance.	

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F 323	Continued From page 36	F 323		

CNA (#8) assisted Resident #2 to stand, provided perineal care, and pivoted the resident back into her wheelchair.

Observation on 05/17/16 at 1:49 p.m. showed a CNA (#8) brought Resident #2 to the bathroom in her wheelchair, placed a gait belt around her waist, and attempted to assist the resident to stand. Resident #2 stated, "I can't do it," and sat back down in the wheelchair. The CNA then called for assistance and instructed the other CNA to bring a lift. A short time later, an unidentified CNA entered the room without a lift, and assisted the CNA (#8) to pivot Resident #2 to and from the toilet.

During an interview on 05/18/16 at 10:06 a.m., a CNA (#8) stated Resident #2 used a full body lift after her fall (in February), but she usually transfers with two people. The CNA also identified she has used a sit-to-stand lift on occasion.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included unspecified pain, arthropathy, dementia, and generalized muscle weakness. The resident's current MDS, dated 04/29/16, identified extensive assistance from two or more people for transfers. The current care plan stated, ". . . TRANSFER: Assist w/ transfers varies throughout the day. Assist of 2. Mechanical lift as indicated. . . ."

Observations of transfers on 05/17/16 at 7:56 a.m., 05/17/16 at 11:24 a.m., and 05/18/16 at 8:36 a.m. showed two staff members assisted Resident #5 out of bed with a full body lift.

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F 323	Continued From page 37 Resident #2 and #5's care plans lacked specific and consistent transfer methods, which enabled unlicensed staff (CNAs) to assess these residents for the most appropriate tranfer method, rather than seeking clarification from licensed staff (nurses). In addition, transferring/attempting to transfer Resident #2 with only one staff member placed the resident at risk for falls and injury.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure 2 of 2 sampled residents (Resident #5 and #6) who required thickened liquids and staff assistance to obtain fluids, received fluids during cares. Failure to offer fluids during cares placed these residents at risk for dehydration, constipation, urinary tract infections (UTIs), and fluid/electrolyte imbalances. Findings include: Review of the facility policy titled "Hydration Implementation Suggestions" occurred on 05/19/16. This policy, dated September 2012, stated, ". . . Nursing assistants/nursing staff could offer fluids to residents upon awakening, during care, and upon repositioning of the resident. . . .	F 327	1) Resident #6 has thickened liquids at bedside and the water is being provided during cares. Resident #5 has expired 5-24-2016. 2) All residents who require thickened liquids have the potential to be affecting in this area. A list of resident currently receiving thickened liquids will be generated and each resident will have thickened liquids at bedside to be used during cares. 3) An All Staff held on 6-15-2016 will be held to educate staff on the procedure titled, “Hydration” and “Residents at Risk for Dehydration/Fluid Maintenance” with a	6/23/16

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F 327	Continued From page 38 Offer hydration between meals because excess fluids at meals may lead to decreased food intake and weight loss. . . ." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia, constipation, and a history of UTIs. The resident's current care plan stated, ". . . at risk for constipation r/t [related to] has hx [history] of constipation, has decreased mobility, psych [psychoactive] med [medication] use. . . . Provide fluids with meals and in between meals, receives Nectar thick liquids. . . ." Observations of Resident #5's personal cares occurred on 05/16/16 at 4:50 p.m., 05/17/16 at 7:56 a.m., 05/17/16 at 11:24 a.m., and 05/18/16 at 8:36 a.m. with various staff members. Observations showed staff failed to offer Resident #5 fluids during any of these interactions. Observations throughout the survey until the morning of 05/19/16 showed no fluids available in Resident #5's room. - Review of Resident #6's medical record occurred on May 16-19, 2016. The current quarterly Minimum Data Set (MDS) for Resident #6, dated 05/12/16, identified the following: usually makes self understood, severely impaired cognition, and requires the supervision of one person for eating. The current plan of care for Resident #6 in regard to eating/drinking stated, ". . . requires assistance with all ADL's [activities of daily living] and mobility r/t dx: [diagnosis] dementia . . . has	F 327	focus on the need for residents on thickened liquid to have and be offered thickened water during cares. 4) An audit will be developed to monitor the residents on thickened liquids checking to ensure thickened liquids are available and offered during cares. The DNS, or designee, will be responsible for the completion of the audit weekly X 4 weeks, then monthly X 2 months. A summary report will be provided to the monthly QA committee for further recommendations for monitoring to ensure compliance.	

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F 327	Continued From page 39 bladder incontinence r/t decreased mobility . . . daily use of diuretic . . ." INTERVENTION - ". . . EATING: assist of one [staff member]: provide needed set up, cueing, supervision or assistance during care as needed . . . Provide nectar thick fluids at meals & between meals, cue & coax as needed for [resident's name] to take fluids as she tolerates . . ." Observations of all cares on Resident #6 showed no fluids offered before or after these cares were provided. These observations included the following: * 05/17/16 at 10:55 a.m. - two certified nursing assistants (CNAs #17 and #18) ambulated the resident in the hallway. * 05/18/16 at 9:05 a.m. - two CNAs (#9 and #16) attempted to toilet the resident, and the resident refused. * 05/18/16 at 11:00 a.m. - one CNA (#15) toileted the resident. * 05/18/16 at 3:30 p.m. - one CNA (#15) attempted to toilet the resident, and the resident refused. * 05/19/16 at 9:05 a.m. - one CNA (#14) toileted the resident. Observations throughout the survey until the morning of 05/19/16 showed no fluids available in Resident #6's room. During an interview on 05/19/16 at 1:12 p.m., a consulting nurse (#7) stated staff are expected to offer fluids with cares, and all residents should have drinking water available in their rooms (or cups of pre-thickened water/fluids).	F 327		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		6/23/16

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F 329 SS=D	Continued From page 40 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on resident interview, record review, review of professional reference, review of facility policy, and information received from the complainant, the facility failed to ensure a medication regimen free from unnecessary drugs for 1 of 4 sampled residents (Resident #3) with a history of anemia and 1 of 3 sampled residents (Resident #2) who received as needed (PRN)	F 329	See also F 309 1) Resident #3 discharged on 5-29-2016. Resident #2's PRN Seroquel was discontinued on 3-14-2016. 2) A) All residents who receive anemia medication injections have the potential to	

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F 329	Continued From page 41 antipsychotic medications. Failure to ensure the necessity of a medication prior to administration places residents at risk of receiving unnecessary medications and suffering adverse consequences related to their use. Findings include: Information received from the complainant identified Resident #3 received an unnecessary injection for anemia. The "Nursing 2015 Drug Handbook," 35th Edition, Wolters Kluwer, Pennsylvania, pages 394-396, stated, ". . . darbepoetin alfa . . . Aranesp . . . Indications & Dosages . . . Anemia from chronic renal failure . . . For patients with chronic renal disease who are on dialysis, if the hemoglobin level approaches or exceeds 11 g/dL [grams per deciliter], reduce dosage or interrupt therapy . . . Black Box Warning: Patients with chronic renal disease have an increased risk of death and serious CV [cardiovascular] events, including stroke, when erythropoiesis-stimulating [i.e. red blood cell producing] agents are used to increase hemoglobin level to greater than 11 g/dL. . . ." Review of the facility policy titled "Medication Administration, Including Scheduling and Medication Aides" occurred on 05/19/16. This policy, revised May 2016, stated, ". . . All staff members passing medications will be familiar with action and adverse reactions of medications. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses	F 329	be affected in this area. No other resident receive PRN anemia injections at this time. B) All resident that have both a PRN antipsychotic medications and a pain medication have the potential to be affected. A list of resident receiving both PRN psychoactive medications and a pain medication will be generated and use for auditing for compliance. 3) All nursing staff meeting held on 6/15/16 to educate staff on injectable anemia medications, “Medication Administration,” and “Psychopharmacological Medications and Sedatives/Hypnotics” with a focus on the need for staff to check physician order if a lab value is needed prior to administering this type of injectable anemia medication, the need to attempt and document non-pharmacological interventions prior to the administration of a PRN antipsychotic, and that PRN antipsychotics cannot be combined with a pain medication. 4) An audit will be developed to monitor the physician order for injectable anemia medication to ensure lab values are available prior to administering injectable anemia medications. Audit will also monitor if a PRN antipsychotic medication has been given in combinations with a pain medication. The DNS, or designee, will be responsible for the completion of the audit. The audit will be completed weekly X 4 weeks, then monthly X 2	

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F 329	Continued From page 42 included end stage renal disease and anemia in chronic kidney disease. The resident's current Minimum Data Set (MDS), dated 04/11/16, identified intact cognition, clear speech, and able to make self understood/understand others. Medications included Aranesp 60 mcg/0.3 ml (micrograms per milliliter) inject every Friday (started 04/08/16 and discontinued 04/22/16). During an interview on 05/18/16 at 7:50 a.m., Resident #3 stated on 04/22/16, she received an injection of Aranesp that she did not need. She identified her dialysis nurse called her on 04/21/16 and stated, "You're supposed to get a shot tomorrow, but do not take it. You don't need it." Resident #3 stated she told the nurse repeatedly she did not need the shot, but "it was like they didn't believe me." Resident #3's April 2016 medication administration record (MAR) identified staff gave the Aranesp injection on the morning of 04/22/16. Further review of Resident #3's medical record identified a hemoglobin value of 12.8 g/dL, drawn on 04/20/16. A dialysis note, dated 04/21/16 at 11:14 a.m., stated, ". . . Hold Aranesp per protocol. Restart Aranesp at lower dose when Hgb [hemoglobin] < [less than] 10.8 [g/dL]. . . ." Failure to verify Resident #3's statements with the dialysis center and monitor hemoglobin values resulted in Resident #3 receiving an unnecessary medication and placed her at risk for life-threatening cardiovascular complications. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses	F 329	months. A summary report will be provided to the monthly QA committee for further recommendations for monitoring to ensure compliance.	

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F 329	Continued From page 43 included Alzheimer's disease, epilepsy, and unspecified psychosis. The record identified a fall which occurred 02/01/16 and resulted in a femur fracture. Upon return to the facility, on 02/05/16, Resident #2's orders included Oxycodone 5 milligrams (mg) every 4 hours PRN for severe pain (order discontinued 03/13/16). Resident #2 also had an order for Seroquel (an antipsychotic) 25 mg once daily PRN (order discontinued 03/14/16). Resident #2's medication administration notes identified the following: * 02/20/16 at 9:31 a.m.: ". . . Oxycodone . . . 5 MG . . . every 4 hours as needed for severe pain . . ." * 02/20/16 at 9:32 a.m.: ". . . Seroquel Tablet 25 MG . . . resident crying and unable to console. . . ." * 02/27/16 at 9:01 a.m.: ". . . Oxycodone . . . 5 MG . . . every 4 hours as needed for severe pain . . ." * 02/27/16 at 9:01 a.m.: ". . . Seroquel Tablet 25 MG . . . resident kicking and yelling at staff, resident is also trying to bite staff. Attempted to redirect with no results. . . ." *03/21/16 at 11:37 p.m.: ". . . Resident had a good night, No agitation noted. Does need a UA/UC [urinalysis/urine culture] and CBC [complete blood count]. resting well at this time. . . ." *03/22/16 at 5:00 a.m.: ". . . Gave resident PRN liquid ativan [at] [4:00 a.m.] for CBC draw and UA collection. Attempted blood draw x2 [twice] to left arm and unsuccessful. Attempted cath [catheter] UA and resident was aggitated [sic] and uncooperative. . . ."	F 329		

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F 329	Continued From page 44 The above notes identified facility staff administered Oxycodone and Seroquel simultaneously on two occasions. This does not allow staff to effectively determine whether one medication alone would have given Resident #2 sufficient relief. In addition, staff also administered PRN Ativan prior to drawing a UA/CBC without first assessing the resident to determine if the medication was necessary. As a result, Resident #2 may have received unnecessary medications and suffered adverse reactions related to their use.	F 329		
F 371 SS=B	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 review, review of manufacturer's guidelines, and staff interview, the facility failed to ensure adequate concentration of sanitizing solution in 1 of 1 kitchen area. Failure to test the sanitizing solution according to manufacturer's guidelines and the facility policy may result in ineffective sanitization of food contact surfaces and dining room tables which could affect all residents and staff eating the food prepared in the facility's kitchen.	F 371	1) Kitchen sanitization testing strips have been orders and are now being used to test dietary chemicals daily according to procedure. 2) All residents have the potential to be affected in the area. 3) A Mandatory Kitchen staff meeting was held on 6-9-2016 to educate staff on	6/23/16

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F 371	Continued From page 45 Findings include: Review of the facility policy titled "Sanitizing Solutions" occurred on 05/17/16. This policy, revised February 2016, stated, "Purpose: To promote the effective use of sanitizing solutions on direct contact surfaces used for food preparation. Procedure: . . . 2. Mix chemicals used in the recommended concentration of levels for maximum efficiency. Refer to manufacturer's information for proper concentrations measured in parts per million (ppm). High concentrations can be unsafe and may leave an odor or bad taste on the objects and corrode metals. . . . 6. Check solution concentrations frequently with a test kit since they may become depleted when they kill microorganisms and bind with food. . . ." - On 05/17/16 at 9:25 a.m., observation showed a dietary staff member (#2) filled a bucket with solution from an automatic dispenser labeled "146 Multi-Quat [quaternary]." Observation showed the manufacturer instructions for "Oasis 146 Multi-Quat Sanitizer" hung on the wall by the dispenser, and included the use of Hydrion QT-40 test strips with the recommended concentration level of "150-400 ppm." When the staff member was asked to test the level of the Quat concentration prior to cleaning the dining room tables, she stated the facility did not use test strips. The staff member (#2) stated staff obtained a new bucket of sanitizing solution for each meal prepped and a new bucket for cleaning the dining room tables after each meal. The surveyor then provided Hydrion QT-40 test strips, tested the solution, and obtained a result	F 371	procedure titled “Sanitizing Solutions” with the focus on the need to test kitchen chemicals concentrations daily. 4) An audit will be developed to monitor compliance of the daily chemical testing. The DDS, or designee, is responsible for the completion of the audit. The audit will ensure proper concentration of sanitization chemicals and will be completed 1 X week X 4 weeks, then monthly X 2 months. A summary report will be provided to the monthly QA committee for further recommendations for monitoring to ensure compliance.	

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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 371	Continued From page 46 of 200 ppm. The staff member stated a representative from the chemical company checked the dishmachine and chemicals about once a month. A dietary manager (#3) stated the representative has not provided the facility any reports on the level of chemical concentration. The manager (#3) confirmed the facility did not test the concentration level of the Quat buckets and had no strips for testing the Quat level as per facility policy.	F 371		
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.	F 441		6/23/16

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F 441	Continued From page 47 (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 infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 2 of 3 sampled residents observed during perineal care (Resident #2 and #5). Failure to perform hand hygiene after perineal care may result in the spread of microorganisms to other residents, staff, and visitors. Findings include: Review of the facility policy titled "Hand Hygiene and Handwashing" occurred on 05/19/16. This policy, revised March 2016, stated, ". . . If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning hands: . . . After removing gloves . . ." - Observation on 05/17/16 at 8:50 a.m. showed a certified nursing assistant (CNA) (#8) assisted Resident #2 with morning cares in the resident's bathroom. After donning gloves and assisting the resident to stand from the toilet, the CNA	F 441	1) Resident #2 staff are using proper hand hygiene according to facility procedure during cares. Resident #5 has expired 5-24-2016. 2) All residents have the potential to be affected by in this area. 3) An all staff meeting held on 6/15/16 to education staff on the procedure titled, “Hand hygiene and proper hand washing” with a focus on the need for staff to wash their hands per procedure. 4) The DNS or designee will audit staff hand washing weekly X 4weeks, then monthly times 2 months. A summary report will be provided to the monthly QA committee for further recommendations for monitoring to ensure compliance.	

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F 441	Continued From page 48 performed perineal care. The CNA then removed her gloves, pulled up the resident's brief and pants, and assisted her to sit in the wheelchair. Without performing hand hygiene, the CNA donned a new pair of gloves and assisted Resident #2 to brush her teeth. The CNA removed her gloves and then cleaned the resident's glasses, combed her hair, and took her to breakfast. The CNA heated up the resident's breakfast tray in the microwave, and then washed her hands. The CNA failed to perform hand hygiene after performing perineal care and removing her gloves. - Observation on 05/17/16 at 7:56 a.m. showed a CNA (#8) assisted Resident #5 with morning cares while the resident was in bed. After donning gloves and performing perineal care, the CNA removed her gloves, pulled up the resident's brief and pants, and placed a mechanical lift sling under the resident. After transferring Resident #5 to her wheelchair, the CNA put on new gloves; washed, dried, and lotioned the resident's back and underarms; removed her gloves; and assisted the resident with her shirt. Because the resident was fatigued, the CNA transferred her back into bed. The CNA then performed oral cares and combed the resident's hair before washing her hands. The CNA failed to perform hand hygiene after performing perineal care and removing her gloves. During an interview on the afternoon of 05/19/16, a supervisory nurse (#4) verified staff should perform hand hygiene after perineal cares.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory	F 502		6/23/16

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F 502	Continued From page 49 services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure adequate laboratory (lab) services to meet residents' needs 1 of 3 sampled residents (Resident #2) with a history of urinary tract infections (UTIs). Failure to ensure adequate monitoring of pending lab work and timely reporting of lab results resulted in a delay in treatment for Resident #2 and an unnecessary procedure (a second urinalysis [UA]). Findings include: Review of the facility policy titled "Laboratory Services" occurred on 05/19/16. This policy, dated September 2012, stated, ". . . Clinical laboratory services will be provided or obtained to meet resident needs. The center assumes the responsibility for the quality, standards, and timeliness of these services. . . . Laboratory services will be done only when ordered by the attending physician. Findings will be promptly reported to the physician. Reports will be dated and filed in the resident's medical record . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia and a history of UTIs. The record identified the following: * A physician's order, dated 03/13/16 at 1:45 p.m.: ". . . Straight cath [catheter] send UA one	F 502	See also F 315 1) Resident #2 has been treated for the UTI and returned to baseline. 2) All residents with physician orders for a urine analysis have the potential risk. 3) An all staff meeting will be held on 6-15-2016 to educate the staff on the procedure titled, “Laboratory Services,” with a focus on the need for timely notification to physician and treatment of positive urine analysis test results. 4) An audit will be developed and completed by the DNS, or designee, to focus on the timeliness of physician notification of positive urine analysis to avoid the delay in treatment. The audit will be completed weekly X 4 weeks, then monthly X 2 months A summary report will be provided to the monthly QA committee for further recommendations for monitoring to ensure compliance.	

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F 502	Continued From page 50 time only . . ." * A nurse's note, dated 03/13/16 at 7:34 p.m.: ". . . straight cathed for 60 ml [milliliters], pt [patient] had already voided in brief, urine clear, collected, placed in fridge. . . ." * A nurse's note, dated 03/13/16 at 8:36 p.m.: ". . . Addendum . . . urine was collected at 1345 [1:45 p.m.]. . . ." * A fax to the physician, dated 03/21/16 at 12:15 p.m.: ". . . UA was done on [Resident #2] on 3-16-16. No UC [urine culture] was done. She has no UTI symptoms at this time. Do you want to treat or monitor? . . ." The physician responded, "Culture urine." * A nurse's note, dated 03/21/16 at 11:37 p.m.: ". . . Resident had a good night, No agitation noted. Does need a UA/UC and CBC [complete blood count]. resting well at this time. . . ." * A nurse's note, dated 03/22/16 at 5:00 a.m.: ". . . Gave resident PRN [as needed] liquid ativan [at] 0400 [4:00 a.m.] for CBC draw and UA collection. Attempted blood draw x2 [twice] to left arm and unsuccessful. Attempted cath UA and resident was aggitated [sic] and uncooperative. Resident had voided in brief. Still need UA/UC and CBC . . ." * A nurse's note, dated 03/23/16 at 6:38 p.m.: ". . . UC results >[greater than] 100,000 e-coli [Escherichia coli]. MD [medical doctor] to review on house rounds 3-24-16. . . ." * A Physician's Note, dated 03/24/16, stated, ". . . HPI [history of present illness] 1) UA/UC redone . . . Plan/orders: Await urine C&S [culture and sensitivity] . . ." A lab report identified receiving a urine specimen on 03/15/16 at 2:00 p.m. (two days after the order) with a final result of "Abnormal" dated	F 502		

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F 502	Continued From page 51 03/16/16 at 12:49 p.m. Resident #2's medical record failed to identify facility communication with the physician regarding this abnormal result until 03/21/16 (eight days after the order). At that time, staff obtained a second UA/UC on 03/22/16, which was positive for E. coli infection according to the final UC result dated 03/24/16. The record identified Resident #2 received Bactrim (an antibiotic) for the UTI. During an interview on 05/18/16 at 11:45 a.m., a supervisory nurse (#4) stated staff obtained the urine sample on 03/13/16, but did not send it until 03/15/16. Staff had to obtain a second urine sample because the first sample sent was not available to culture. Failure to follow-up on a pending UA and promptly discuss results with the healthcare provider resulted in a delay in antibiotic treatment and subjected Resident #2 to an unnecessary procedure (a second catheterization), which included administration of PRN liquid Ativan.	F 502		