RECEIVED
NOV 12 2013
Division of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on September 23, 2013 and completed on September 26, 2013, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included three (3) additional residents to verify specific concerns during the survey.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation	
F 222 SS=G	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure 3 of 7 sampled residents (Resident #1, #2, and #5) remained free of chemical restraints imposed for the purposes of discipline or staff convenience. Failure to assess and implement behavioral interventions to manage Resident #1, #2, and #5's behaviors resulted in the frequent utilization of psychotropic medication for the purpose of discipline and/or convenience. Findings include: - Resident #5's medical record, reviewed September 23-26, 2013, identified diagnoses including Alzheimer's dementia, anxiety, and pain. The resident's quarterly Minimum Data Set (MDS), dated 07/27/13, identified problems with	F 222	F 222 1. Resident # 1's individual needs have been met by discontinuing the PRN Ativan on 11-04-2013. The regularly scheduled Ativan dose has not been changed. Remeron was started on 4-26-2013 with help to decrease the need for the PRN Ativan. Non pharmacological interventions have been added to the care plan to be tried and documented prior to the administration of any PRN psychoactive medication.	

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 222	Continued From page 1 memory, moderately impaired daily decision making skills and extensive assistance required for activities of daily living (ADLs). The antipsychotic Care Area Assessment (CAA), completed 05/10/13, further identified, ". . . The prn [as needed] ativan dose was recently decreased due to too sedating. [sic] . . . On 05/07/13 the ativan dose was again increased. . . ." The current care plan identified, "Problem: Alteration in mood/behaviors r/t [related to] dementia, delusiona [sic] disorder . . . Approaches: Observe/report changes in mood/behavior, Mental health referral as needed, Remove scissors from room . . ." The physician's orders identified the following: * 07/11/12, Lexapro (an antidepressant) 10 mg daily at hour of sleep for anxiety * 02/20/13, Risperdal (an antipsychotic) 0.25 mg twice daily for delusions * 05/08/13, Ativan 0.5 mg every four hours as needed for agitation/restlessness The progress notes identified the following: * 04/27/13 at 2:00 a.m., ". . . Res attempting to self stand . . . [medicated with] ativan . . ." * 05/03/13 at 6:35 a.m., ". . . did not want to stay in bed - didn't seem to comprehend that it was her usual time that she goes to bed - ativan . . . given with good results - was much more relaxed [and] then settled into sleep - slept well [after] wards without complaints or trying to get [up] out of bed." * 05/06/13 at 3:30 p.m., "Ativan . . . will not stay in bed . . ." * 05/07/13 at 1:30 p.m., ". . . Resident was laid down to rest but did not stay there very long. Was	F 222	Resident #2's individual needs have been met by changing the Ativan to be regularly scheduled. She is sleeping in her bed instead the Broda chair. Her care plan was reviewed to ensure the resident has a mood and behavior care plan problem has been updated to address her sleep, comfort, the addition of non pharmacological interventions, and adverse consequences including falls. The LPTA adjusted her wheelchair seat to prevent her from leaning or falling forward out of her wheelchair. She has not fallen from the wheel chair since this modification on 10-21-2013. Care plan has been updated to include non pharmacological interventions specifically sundowner's syndrome and verbal and physical abuse to staff. The care plan have been updated to include her current fall precaution interventions including a sensor matt to her bed and chair. The LPTA adjusted her wheelchair seat on 10-21-2013 to prevent her from leaning or falling forward out of her wheelchair and she has not fallen from the wheel chair since this modification. Resident #5 expired on 10-22-2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 222	Continued From page 2 given ativan . . ." * 05/08/13 at 7:45 a.m., "Resident . . . started climbing out of bed again," and at 10:30 a.m., "Resident remains restless Ativan . . . given." * 05/15/13 at 1:00 p.m., ". . . CNA attempted to lay resident down but she kept getting out of bed so they put her back in her w/c," and at 1:30 p.m. "Ativan . . . given for anxiety/restlessness [and] laid back down . . . resident did stay in bed at this time." * 05/16/13 at 12:00 p.m., "restless not wanting to stay in her w/c [wheel chair] - ativan . . . given" * 05/18/13, "Resident . . . attempting to get out of her w/c ativan [given] . . ." * 05/22/13 at 1:30 p.m., ". . . restless staff attempted several times to lay back down but resident attempted to get out of bed - staff got her up in w/c," and at 2:30 p.m., "medicated . . . [with] ativan . . ." * 05/26/13 at 7:00 p.m., ". . . resisting staff's attempts at helping her get ready for bed was given . . . ativan . . . which was effective." * 05/31/13 at 9:30 p.m., "Resident . . . attempting to get [up] out of bed . . . was given ativan . . . [with] good results." * 06/04/13 at 12:30 p.m., "Resident . . . refusing to sit in her w/c staff unable to get her to sit down - ativan . . . given," and at 2:00 p.m., "Resident resting quietly in bed." * 07/06/13 at 1:30 p.m., "Resident . . . keeps standing up out of w/c . . . ativan given . . ." * 08/05/13 at 1:00 a.m., "Resident . . . Was given ativan . . . with little effect. Patient continues to attempt to get out of bed. . . ." * 08/16/13 at 3:30 p.m., "Resident . . . medicated [with] . . . ativan which did not help . . . she cont [continued] to attempt to get out of w/c." Failure of the facility to appropriately assess and	F 222	2. Residents that receive PRN psychotropic medications have the potential to be affected in this area. A list of resident that receive PRN psychotropic medications will be generated and each resident on the list will have their care plan reviewed for a mood and behavior care plan problem with non pharmacological interventions, to be tried and documented prior to the administration of a PRN psychoactive medications, and potential adverse consequences include the risk for falls. 3. All nursing staff and social services staff will be educated on 11-12-2013. The procedure titled, "Psychopharmacological medication" will be reviewed with a focus on the need for staff to offer and document non pharmacological interventions prior to the administration of PRN psychotropic medications and to address adverse consequences of psychoactive medications including the risk for falls.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 222	Continued From page 3 implement behavioral interventions to manage Resident #5's behaviors (attempts to rise from her bed/chair) resulted in the frequent utilization of Ativan to control her behaviors for staff's convenience. - On the morning of 09/23/13, a supervisory nursing staff member (#1) stated Resident #2 doesn't sleep in her bed, but rather sleeps in a Broda chair (a tilt and recline positioning wheelchair/chair). Review of Resident #2's medical record occurred on all days of survey. Resident #2's medical diagnoses included senile dementia, mood disorder, anxiety, agitation, and degenerative disc disease. Resident #2's medication regimen identified orders for Ativan, an antianxiety medication, as follows: * 04/04/12: Ativan 0.5 mg (milligrams) to one mg by mouth every 4 hours as needed for anxiety; discontinued on 11/02/12 * 04/04/12: Ativan 0.5 mg one to two tablets by mouth every 6-8 hours; discontinued on 09/07/12 * 09/07/12: Ativan 0.5 mg to one mg intramuscularly (IM) every 4 to 6 hours as needed for agitation; discontinued 11/02/12 On 11/02/12, a psychiatrist ordered Trazadone, an antidepressant, three times a day Resident #2's current medication regimen included the following with corresponding start dates: * 09/06/12: Prozac (an anti-depressant) 10 mg every day * 09/07/12: Fentyl patch (a narcotic pain medication for moderate to severe pain) 25 mcg	F 222	4. An audit tool will be developed to monitor PRN psychoactive medications. The audit will focus on the care plan for mood and behaviors, documentation of non pharmacological interventions, and adverse consequences listed on a mood and behavior care plan. The audit will be completed by the DNS or designee, weekly for 4 weeks, then monthly for two months. The results of the audits will be reported to the QA committee for further recommendations. 11-29-2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 222	Continued From page 4 (micrograms)/hour every 72 hours * 01/18/13: Symbyax 6/50 mg (a combination drug of Zyprexa 6 mg - an anti-psychotic medication, and Prozac 50 mg) every day at bedtime * 03/05/13: Trazadone (an antidepressant) 150 mg every evening * 09/20/13: Symbyax 3/25 mg everyday at bedtime in addition to the 6/50 mg * Oxycodone (a narcotic pain medication for moderate to severe pain) 5 mg every 6 hours as needed. The record showed nursing staff administered two doses in June; three in July, and two in August A comprehensive assessment for the annual Minimum Data Set (MDS), dated 03/02/13, identified the following care areas triggered: * Communication: ". . . is confused d/t [due to] Dx [diagnosis] Dmentia [sic] . . . She is also restless. Her confusion has been long standing. She continues to require meds [medication] for restlessness, and has varying mood tones from pleasant to aggitiated [sic]. She is not showing s/s [signs or symptoms] of adverse side effects. She is on multiple psychotropic with adjustment [sic] so is at risk for adverse side effects." * Psychotropic Drug Use: ". . . Resident is on psychoactive medications for her mood and behavior issues. She has mood disorder requiring treatment. . . . Adverse consequences . . . Sedation . . . drowsiness, little/no activity involvement . . . Resident is at risk for falls due to cognition and physical function deficits . . . can be very restless at times. . . ." Resident #2's current care plan identified the problem of "Impaired mobility and potential for falls r/t [related to] dementia, arthritis . . ." with	F 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 222	Continued From page 5	F 222		

approaches of "Will not sleep in bed. Place in Broda chair or recliner at bedtime. . . ." The record identified the use/availability of a Broda tilt-n-space chair since on 05/22/12. The purpose of the chair being "helps her get restful sleep."

Observations of Resident #2 on all days of survey identified Resident #2 frequently resting during the day hours with eyes closed. These observations occurred while Resident #2 sat in a recliner near the nurses' station, at a table near the nurses' station, during a group activity (a Bible study), and during meals. During the survey, random interviews with nursing staff reported Resident #2 slept poorly during the night.

Resident #2's record identified falls six falls which occurred from the wheelchair.

Staff administered Lorazepam/Ativan by mouth or IM at various times of the day beginning on 09/27/12 and at least once or twice daily throughout the month of October for behaviors. Several of the behaviors were related to the resident's attempts to get out of her chair or bed, restlessness, or failure to sleep during the night. The record included the following entries:
* On 09/27/12 at 7:30 a.m. a nurse gave Resident #2 Lorazepam "for anxiety, agitation" with short-term relief.
* 09/28/12 at 6:00 a.m., "Resident was restless and anxious, PRN [as needed] ativan IM was given at 9:00 p.m. Resident was awake in bed, trying to climb out of bed. There was no relief for the 9 PM PRN ativan. At 1:00 a.m. PRN IM 0.5 [mg] was given with relief. Resident is sleeping comfortably. . . ."
* 09/29/12 at 3:00 a.m., "Resident has been restless tonight. Medicated [with] ativan et [and] it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 222	Continued From page 6	F 222		

has not been effective. Res. [resident] is up in w/c [wheelchair] now and is crying and restless. . . ."
* 09/30/12 at 1:00 a.m., "Resident has been crying et anxious throughout shift, also restless, does not sit still. Ativan po et [and] IM given per orders, it is not effective . . . Resident was crying stating 'I'm scared' et pounding on the wall; redirection is difficult as res. has very short attention span."
* 10/01/12 at 5:05 a.m., ". . . restless during shift. Does not sit still. Was in w/c [wheel chair] at nurse's station for much of the night. Ativan po & IM given. . . . Was not very effective. Redirection not effective due to short attention span. Also seemed to agitate her at times."
* 10/02/12 at 3:30 a.m., ". . . placed in recliner. . . restless during first part of shift. Would self propel self in w/c around nurse's station becomes very anxious. Medicated x 2 [two times] [with] PRN ativan as directed. Resident has been sleeping since."
* On 10/04/12 between 3:00 p.m. and 10:00 p.m., nursing staff "Medicated x 2 for anxiety."
* On 10/06/12 at 7:15 a.m., nursing staff administered Resident PRN ativan IM for being "anxious and restless early in the shift. . . ."
* On 10/19/12 at 3:15 p.m. nursing staff administered the Lorazepam as "Resident very anxious and restless this a.m. Trying to get out of w/c [wheelchair]. Nurse administered 1 mg Ativan 7:20 [a.m.]. Ate some of breakfast and took all [8 a.m.] meds. Resident fell asleep shortly after. Sleeping most of morning into afternoon [3 p.m.] . . . Remains sleeping in recliner. . . . [No] [noon] medications or dinner." The medication administration record (MAR) identified Resident #2 received two doses of prn IM Ativan and one dose of prn Ativan orally on 10/19/13.
* On the afternoon of 10/20/12 a nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 222	Continued From page 7	F 222		

documented, "Resident was very restless during the afternoon. She was preoccupied [sic] by staff. Res [resident] had crying episodes and would try to get out of chair. She would slip her body off her chair. Medication was given for restlessness". The MAR identified the nurse administered Ativan IM and at 4:35 p.m., "Resident was found on the floor face down." The incident report identified the nurse administered the Ativan prior to the fall.
* On 10/25/12, a nursing staff member faxed a psychiatrist, "[primary care physician-PCP] has prescription for Lorazepam for [Resident #2] - as Resident is given the PRN (po) dose 1-3 x daily & we use IM Ativan also - [the PCP] wants you to prescribe the Lorazepam . . ."
* On 11/01/12, Resident #2's PCP discontinued the oral and IM orders for Ativan and the psychiatrist, per a telephone order, ordered Trazadone (an anti-depressant).

Interdisciplinary Progress Notes (IDPN), between 11/16/12 and 11/26/12 included six entries regarding Resident #2 not sleeping at night. The notes included, ". . . Noc [night] nurses report that she does not go to sleep until around 0100 [1:00 a.m.]. . . Noc nurse reported res. slept a 'few' hours last noc . . . Night nurse reported [Resident #2] 'up all noc' . . . Hollering from 7 p.m. till midnight. Slept from 12 [midnight] - 3 A [a.m.] . . ."

IDPN, dated 11/26/12 at 5:50 p.m. stated, "Return call from [psychiatrist] re [regarding] insomnia/anxiety give Haldol (an anti-psychotic medication) 5 mg po at hs [bedtime] tomorrow (11/27) . . . Call [psychiatrist] in AM of 11/28 to report effect on sleep - Then [check] after 11/27 give Haldol 5 mg po daily at hs PRN insomnia/anxiety." The IDPN notes identified that on the night of 11/28 (after 11/27 dose of Haldol)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 222	Continued From page 8 "resident was awake almost all night. - [psychiatrist] office contacted & updated. On the morning of 11/29/12 (after Resident #2 received two consecutive doses of Haldol), nursing wrote, ". . . she only slept 1-1 1/2 [one to one and a half hours] all night." A nursing staff member contacted the psychiatrist's office and Seroquel (an anti-psychotic) 100 mg once per day PRN was ordered, and the psychiatrist discontinued the Haldol. Following one dose of Seroquel, the psychiatrist discontinued the medication as "Nursing staff reported since she had taken the new order for Seroquel - noted she was having tremors. . . ." During interview on 09/26/13 at 9:00 a.m., a social services staff member (#7) stated nursing staff cannot "contain" Resident #2. The staff member stated she did not know if there is a known cause for Resident #2's behaviors. Failure to assess and implement behavioral interventions to manage Resident #2's behavior resulted in utilization of Ativan to control her behaviors and the presence of adverse effects including falls. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included senile dementia and anxiety. Medications included Ativan 0.5 mg every morning and every 8 hours PRN and Remeron (antidepressant) 15 mg daily. Resident #1's current care plan stated, "Problem . . . Alteration in mood/behaviors R/T anxiety, senile dementia with delusional features . . . medicate as ordered . . . observe/report S/S [signs or symptoms] anxiety: easily annoyed,	F 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 222	Continued From page 9 irritable, tired, worried, restless, startles easily." Review of Resident #1's progress notes and MAR identified nursing staff administered Ativan to the resident for the following: *05/12/13 ". . . one crying spell. . . ." *05/18/13 "restless/agitation" *05/19/13 ". . .. . Resident medicated [with] Tramadol [pain medication] . . . @ [at] 1230 [12:30 p.m.] for upset stomach pain . . . Tramadol effective . . . also medicated @ 1230 [with] Ativan . . . as Resident restless. Ativan . . . also was effective . . ." Facility staff failed to allow time for the pain medication to take effect before they administered the Ativan. *05/20/13 ". . . resisting help with feeding. Refused meds [medications]. . ." The MAR showed PRN Ativan administered for "agitation." *05/28/13 ". . . [no] crying or [increased] anxiety today . . ." The MAR showed PRN Ativan administered for "restlessness." *05/29/13 - The MAR showed PRN Ativan administered for "restless, irritable, anxious." The progress notes failed to identify any behavioral concerns on this day. *05/31/13 - The MAR showed PRN Ativan administered for "restlessness/anxiety." The record did not identify any behavioral concerns on this day. *06/04/13 - The MAR showed PRN Ativan administered for "agitation." The record did not identify any behavioral concerns on this day. Failure to assess and implement behavioral interventions to manage Resident #1's behavior resulted in utilization of Ativan to control her behaviors.	F 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 225 F 225 SS=E	Continued From page 10 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225 F 225	F 225 1. Resident #5 expired on 10-22-2013. Resident #10's individual needs have been met by reporting the incident to the state of ND and following up 5 days later with the investigation results. The bruising on her arm is healed. On 10-14-2013 the resident had additional bruising on her arm. An incident report was generated and the state of ND was informed of the incident. The care plan was updated to include the addition of sheep skin to the arm rest of her wheelchair was added to the care plan. 2. All resident have the potential to be affected in this area. GSC has a critical incident notification process for abuse and neglect reports. The GSC has a zero tolerance policy for abuse, neglect, and financial exploitation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 225	Continued From page 11 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON SEPTEMBER 12, 2012. Based on record review, review of facility policy and procedure, and staff interview, the facility failed ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, were reported immediately to the administrator of the facility and to other officials in accordance with State law for 2 of 13 sampled residents (Resident #5 and #10) identified with injuries and/or misappropriation of property. Failure to identify, report, and investigate allegations of misappropriation of property (controlled medication) (Resident #5) and injuries of unknown origin (Resident #10) placed all residents at risk. Findings include: Review of the facility policy titled "Abuse and Neglect" occurred on 09/26/13. This policy, revised September 2013, stated, ". . . Alleged or suspected violations involving any mistreatment, neglect or abuse including injuries of unknown origin will be reported immediately to the center administrator and to other officials in accordance with state law, including the state survey and certification agency. . . . The center will have evidence that all alleged or suspected violations are thoroughly investigated . . . Results of all investigations will be reported . . . including to the state survey and certification agency within five	F 225	3. An all staff meeting will occur on 11-12-13 to re-educate the staff on the procedure titled, "Abuse and Neglect" and the ND state reporting guidelines for reporting any allegation of mistreatment, abuse or neglect. This includes misappropriation of property, a controlled medication diversion, or injuries of known origin. Review of procedure titled, "Missing or Diverted Medications". When appropriate, follow the procedure titled, "Significant Event Referral" Procedure reviewed including the definition of a significant event that would result in a report to the state of ND. A Significant Event is defined as an occurrence which causes harm to a resident, has the potential to cause harm to a resident, or causes or has the potential to cause a major financial loss to the Society, and which arises out of the performance of professional duties, or a discrepancy in the documentation of a controlled substance. Copies of the Initial Allegation of Mistreatment, Abuse, Neglect, or Theft reporting form is at each nurses' station and includes the fax number of the state health department. The CIN job aid will be reviewed and made available at each nurses' station.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 225	Continued From page 12 working days of the incident . . ." Review of the facility procedure titled "Abuse and Neglect" occurred on 09/26/13. This policy, revised 07/12, stated, "PURPOSE: *To ensure that the center has in place an effective system that, regardless of the source, prevents mistreatment, neglect and abuse of residents or misappropriation of their property . . . *To ensure that all identified incidents of alleged or suspected abuse/neglect are promptly investigated and reported *To ensure that all identified incidents involving injuries of unknown origin are promptly investigated to determine probable cause of unknown origin injuries . . . *To ensure that a complete review of existing incidents is documented *To identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse and to determine the direction of the investigation . . ." - Resident #5's medical record, reviewed September 23-26, 2013, identified diagnoses including Alzheimer's dementia, anxiety, hemangioma [noncancerous tumor] with severe kyphosis [abnormal curvature of the upper spine], history of thoracic and lumbar fractures, recent hip fracture, and abdominal, back, and hip pain. The resident's quarterly Minimum Data Set (MDS), dated 07/27/13, identified problems with memory, moderately impaired daily decision making skills, extensive assistance for activities of daily living (ADLs), and use of scheduled and as needed pain medications. The physician's order, dated 01/19/10, identified "Fentanyl Patch [an opioid analgesic] 150 micrograms (mcg)/hour [for pain] . . . Change	F 225	4. An audit tool will be developed to monitor incident reports for reportable allegations of abuse, neglect, or financial exploitation. The audit will monitor if the incident report is complete, if the incident meets the ND state reporting guidelines, if so, was the incident reported to the state, was the state notification within 24 hours, if an investigation had been conducted, physician contacted, family or POA notified, and follow up report to the state of ND within 5 days. The audit will be completed by the social worker or designee weekly for 4 weeks, and then monthly for two months, the results of the audit will be reported to the QA committee for further recommendations. 5. 11-29-2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 225	Continued From page 13	F 225		

[Fentanyl Patch] q [every] 72 hr [hours]. Disposal of old patch as follows: Two nurses witness patch wrapped in toilet tissue and flushed down toilet. Both nurses sign off disposal. . . ."

Resident #5's progress notes identified the following:
* 01/01/13 at 8:30 a.m., ". . . Resident had 'shakes,' involuntary movement noted. She did not want anyone to touch her during her 'spell.' Began to remove clothing and became very agitated. . . . Resident taken to her room where involuntary movements almost like a seizure-type continued and worsened - unable to obtain blood pressure due to shaking resident crying and wants to go to 'doctor' . . ."
* 01/01/13 at 8:40 a.m., ". . . meals not given orally due to shaking as I worried that she could not swallow them properly . . ."
* 01/01/13 at 9:00 a.m., "Notified [Hospital] ER [emergency room] that resident was going to be sent to ER for above symptoms . . ."

The [Hospital] Discharge Summary, dated 01/03/13, identified, ". . . HOSPITAL COURSE: [Resident #5] . . . admitted into observation . . . Specifically increased agitation compared to baseline. Patient was having trouble sitting still. She would not let anyone touch her to do any kind of assessment. She is complaining of arm and legs and everything hurting. She would also have jerking movements in her arms. . . . It seemed like she would not be able to stop her arms and she would have the jerking for a few seconds and then it would pass for a while. In patient's initial assessment it was noted that she was missing one of her fentanyl patches. Patient is on a total dose of 150 micrograms (mcg) per hour which she receives through one 100 microgram patch in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 225	Continued From page 14	F 225		

combination with one 50 microgram patch. It was found that she had only her 50 microgram patch on. On the day prior patient had also had nausea and diarrhea. All of the symptoms were suspected to be from narcotic withdrawal. . . . FINAL DIAGNOSES: 1. Narcotic withdrawal. . . ."

The progress notes identified the following:
* 01/30/13 at 8:50 a.m., "Resident noted to be missing Fentanyl Patch 50 mcg - none found in room - had been applied to Rt [right] upper anterior chest on 01/28/13 . . ."
* 01/30/13 at 1:00 p.m., "[Nurse Practitioner] notified - [Registered Nurse] also checked resident's skin with me and no patch found . . . "
* 02/18/13 at 9:40 p.m., identified, ". . . Tremors of UE's [upper extremities] - c/o [complains of] 'muscle spasms' - severey [sic] anxiety . . . unable to [check] vs [vital signs] [secondary to] anxiousness/shaking. . . . unable to calm . . . Also noticed Fentanyl patch (applied 02/17) not on . . ."

During an interview on 09/25/13 at 1:30 p.m., an administrative nurse (#3) and a managerial nurse (#15) reported they were unable to locate any investigative reports concerning the three episodes involving the missing Fentanyl patches. They further reported, "We checked the bedding and the laundry."

The facility failed to conduct a thorough investigation to determine no misappropriation of property occurred to Resident #5 and failed to report the missing controlled medication to the state survey and certification agency.

- Review of Resident #10's medical record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 225	Continued From page 15 occurred on September 25-26, 2013. Resident #10's quarterly MDS, dated 06/15/13, identified long and short term memory problems and extensive to total assistance from one or more staff members for bed mobility, transfers, dressing, toilet use, and personal hygiene. Review of Resident #10's nursing notes identified the following: * 09/13/13, "Current Skin Condition - bruises noted to [left] toes, [left] thigh, [left] breast." During interview on the morning of 09/26/13, an administrative staff member (#3) stated no report was available regarding this bruising/injury. * 10/13/12 at 1:30 p.m.: "Nursing staff noted resident holding her contractured (Rt) [right] arm in a position not normal and bruise - yellow/purple to [lower] forearm and [upper] forearm 22 cm x [by] 26 cm [approximately 9 inches by 10 inches] - discomfort, fussing [with] assessment - informed physician per phone - [physician] - shoulder area appears abnormally elevated . . ." Review of the investigation of the injury occurred on the morning of 09/26/13. An administrative staff member (#3) provided the investigation report. The investigation report identified the facility failed to report the injury to the state certification agency within 24 hours and the results of an investigation within five days.	F 225		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 272	Continued From page 16 assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to comprehensively assess the physical, mental and psychosocial needs for 1 of 6 sampled residents (Resident #2) with dementia and on psycho-pharmacological medications. Failure to	F 272	F 272 1. Resident #2's individual needs have been met by reviewing and updating her current Mood and behavior CAA to establish a root cause for her behaviors. Her PRN Ativan has been changed to being regularly scheduled. She is verbally and physical abuse to staff. She yells, swears, pinches, hits, and resists staff assistance. She has a history of wandering, sleep cycle disturbance with fatigue, fall history, and sundowner's syndrome related to her dementia. Adverse consequences added to care plan of risk for falls, nausea, vomiting, changes in eating patterns, and changes in bowel patterns. Non-pharmacological approaches will be added to the care plan. Staff will document at least three non pharmacological interventions prior to the administration of a PRN psychoactive medication. 2. A list of residents with dementia will be generated. Each resident will have their mood and behavior CAA reviewed, care plan checked for a mood and behavior problem, goal statement, and non pharmacological interventions, targeted behaviors, customary routines, and adverse consequences when taking these medications.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 272	Continued From page 17 assess the Care Area Assessments (CAAs) unique to Resident #2 has the potential to affect the care provided. Findings include: Review of Resident #2's medical record occurred on all days of survey. Resident #2's medical diagnoses included senile dementia, mood disorder, anxiety, and agitation. Review of Resident #2's CAAs, dated 03/02/13, stated, ". . . what factors unique to this resident must be considered in formulating the care plan?" The facility identified the following: * Cognitive Loss/Dementia; Mood; Behavioral Symptoms; and Psychological Well-Being: "Redirect and re-orientate [resident] as able and have her express her emotions and concerns as able." * Communication: Cognition, Medical DX [diagnosis] . . ." * Psychotropic Drug Use: "Cognition, Mood/Behavior, Medical DX [diagnosis], Medication usage." * Falls: "Cognition, Physical Function, Medical DX, Medication usage, Mood/Behavior." The facility failed to: * Describe Resident #2's behaviors; including the onset, duration, intensity, possible precipitating events, environmental triggers, and related factors in the medical record with enough specific detail of the actual situation to permit underlying cause identification to the extent possible. * Establish root causes of Resident #2's behaviors using individualized knowledge about the person, including caregivers on all shifts. * Assess how Resident #2 typically	F 272	3. Social services will be inserviced by the GSS national campus Rehab/Skilled Care Consultant on 11-08-2013. The procedure for CAA and Care plan writing will be reviewed with a focus on how to write a CAA and care plan for mood and behavior including non pharmacological interventions, targeted behaviors, and adverse consequences. Nursing staff will be inserviced on 11-12-2013 on the procedure for psychopharmacological medication with a focus on the need for staff to document at least three non pharmacological interventions prior to giving PRN medications and the possible adverse consequences when taking these medication including falls risk, and how to document a mood or behavior in the electronic documentation system mood and behavior module.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 272	Continued From page 18 communicates basic needs such as pain, discomfort, hunger, thirst or frustration. *Evaluate prior life patterns, preferences, and customary responses to triggers such as stress, anxiety and fatigue. * Identify risk and causal/contributing factors for Resident #2's behaviors, including adverse consequences related to the resident's current medications.	F 272	System change: A behavior committee will be established to review all residents that received psychoactive medications. 4. An audit tool will be developed to monitor if the CAA for mood was triggered from the MDS and a care plan started to addresss mood and behavior. Check to ensure that all of the CAA questions have been answered, if non medication intervention were added to the care plan, if staff is documenting at least three different non pharmacological interventions prior to administering PRN psychoactive medications, and that adverse consequences are listed on the care plan. The audit will be completed by the DNS or designee weekly for 4 weeks, then monthly for two months. The results of the audit will be reported to the QA committee for further recommendations. 5. 11-29-2013	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to review and revise	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 280	Continued From page 19 the comprehensive care plan to reflect the residents' status for 3 of 6 sampled residents (Resident #1, #2, and #5) identified with behaviors and on psychopharmacological medications and 5 of 13 sampled residents (Resident #1, #5, #7, #8, and #11) who required as needed (PRN) interventions for bowel elimination. Failure to review and revise the care plans limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: - Review of Resident #2's medical record occurred on all days of survey. Resident #2's medical diagnoses included senile dementia, mood disorder, anxiety, and agitation. The progress notes identified Resident #2 fell from her wheelchair while sleeping on 02/20/13, 08/02/13, and 08/29/13. Review of the quarterly Minimum Data Set (MDS), dated 08/31/13, and the annual MDS, dated 03/02/13, identified Resident #2 wandered 4 to 6 days during the 7 day assessment period. The MDS, dated 08/31/13, identified Resident #2 had behavioral symptoms which included physical and verbal behaviors directed towards others, and other behavioral symptoms not directed toward others. Resident #2's current care plan identified the following problems: * "Impaired mobility and potential for falls r/t [related to] dementia . . ." * "Alteration in mood/behaviors r/t dementia, insomnia, anxiety /agitation, sundowners M/B [manifested by] confusion, restlessness, currently	F 280	F 280 See also F 222, F 225, and F 309 1. Resident #1's individual needs have been met by include non pharmacological interventions, targeted behaviors, adverse consequences of taking the medication including the risk for falls. Resident #2's individual needs have been met by adding non pharmacological interventions specifically for her sundowner's syndrome and verbal and physical abuse to staff. The care plan have been updated to include her current fall precaution interventions including a sensor matt to her bed and chair, her wheelchair seat has been adjusted to be lower in the back and the resident has not fallen from the wheelchair since this seat adjustment. Resident #5 expired on 10-22-2013. 2. All residents that trigger on the MDS for a mood and behavior CAA. The CAAs' will be reviewed for all residents to make sure there is a care plan problem addressing the diagnosis of dementia.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 280	Continued From page 20 on psychoactive meds [medications], behaviors: verbal, physical and resisting cares . . ." * "Dependent on others for all leisure needs R/T cognitive status . . ." Although the facility identified the above problems, they failed to review and revise Resident #2's care plan and include individualized specific approaches related to her cognition, physical function, medical diagnosis, medication usage, and mood/behavior. The care plan failed to provide interventions to decrease and/or prevent falls; address her behavior of wandering; and address her sleep patterns, specifically sundowner's syndrome. - Resident #5's medical record, reviewed September 23-26, 2013, identified diagnoses including Alzheimer's dementia, constipation, anxiety, and abdominal, back, and hip pain. The resident's quarterly MDS, dated 07/27/13, identified problems with memory, moderately impaired daily decision making skills, extensive assistance required for activities of daily living (ADLs) including toileting, and use of scheduled and as needed pain medications. Resident #5's medical record further identified she failed to have a bowel movement for three-to-nine days on 12 occasions, required four manual extractions of stool, was medicated with Oxycodone [a narcotic pain medication] and/or Ativan [an anti-psychotic medication] when she became agitated/restless and attempted to self transfer from her bed/wheelchair on 17 occasions, and was hospitalized for narcotic withdrawal. The current care plan identified the following	F 280	2. Nursing staff will be inserviced on 11-12-2013 on the procedure titled "Psychopharmacological medication" and the need to establish and document non pharmacological interventions prior to giving PRN medications, and possible adverse consequences when taking this medication including falls risk. 4. An audit tool will be developed to monitor is the CAA for mood was completed, if non medication intervention have been added to the care plan, if staff are documenting the attempt to offer at least non pharmacological intervention prior to administering PRN psychoactive medications, and if adverse consequences of staffing for psychoactive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 280	Continued From page 21 problems: * "Altered bowel elimination r/t constipation . . ." * "Potential alteration in mood/behaviors r/t dementia, delusiona [sic] disorder, h/o [history of] psychotic disorder . . ." * "Altered comfort r/t hemangioma to the liver . . . recent hip fracture . . . abdominal pain, left hip pain . . ." Although the facility identified the above problems, they failed to review and revise Resident #5's care plan to include specific individualized approaches based on her medical diagnoses, cognitive skills, behaviors, physical function, and medication usage. The care plan failed to provide interventions: * Addressing Resident #5's frequent use of as needed bowel medications, * Identify specific dietary interventions staff should attempt before/in addition to Resident #5's bowel medications, * Identify specific non-pharmacological interventions staff should attempt prior to administering Ativan during situations in which Resident #5 becomes agitated/restless and attempts to self transfer from her bed/chair, and * Identify specific nonverbal/verbal symptoms of pain/narcotic withdrawal Resident #5 presents with and staff should monitor prior to/following the administration of pain medication. - Resident #7's medical record, reviewed September 23-26, 2013, identified diagnoses including dementia, constipation, and history of venous stasis ulcer. The resident's quarterly MDS, dated 08/19/13, identified moderately impaired cognitive skills, extensive assistance required for bed mobility, transfers, locomotion, and toileting, at risk of developing pressure	F 280	medications have been added to the care plan. The audit will be completed by the DNS or designee weekly for one month then monthly for two months. The results of the audits will be reported to the QA committee for further recommendations. 11-29-2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 280	Continued From page 22 ulcers, and listed the following skin/ulcer treatments: pressure reducing device for bed/chair and applications of ointments/medications. Resident #7's medical record further identified she failed to have a bowel movement for three-to-four days on six occasions, and was recently diagnosed with a 2.5 x 4.5 centimeter deep tissue injury (DTI)/pressure ulcer to her left heel. The current care plan identified the following problems: * "Potential altered bowel elimination: constipation . . ." * "Alteration in skin integrity r/t reduced mobility . . . left heel suspected DTI . . ." Although the facility identified the above problems, they failed to review and revise Resident #7's care plan to include specific individualized approaches based on her medical diagnoses, cognitive skills, behaviors, physical function, and medication usage. The care plan failed to provide interventions: * Addressing Resident #7's frequent use of as needed bowel medications, * Identify specific dietary interventions staff should attempt before/in addition to Resident #7's bowel medications, * Identify specific pieces of clothing/equipment staff should utilize to protect Resident #7 against the adverse effects of pressure, friction, and/or shear, * Identify specific dietary interventions staff should attempt in order to provide sufficient protein to meet Resident #7's healing requirements.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 280	Continued From page 23 - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included constipation. The current care plan identified the following problems: * "Altered bowel elimination R/T constipation . . ." *"Alteration in mood/behaviors R/T [related to] anxiety, senile dementia with delusional features . . ." - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia and constipation. The current care plan stated: "Problem . . . altered bowel elimination R/T constipation, H/O [history of colon CA [cancer] . . ." - Review of Resident #11's medical record occurred on September 25-26, 2013. Diagnoses included Alzheimer's disease and constipation. The current care plan stated: "Problem . . . Altered bowel elimination, diarrhea vs [verses] constipation R/T Alzheimer's dementia . . ." Although the facility identified the above problems for Resident #1, #8, and #11, they failed to review and revise Resident #1's care plan to identify specific non-pharmacological interventions staff should attempt before the administration of an anitanxiety medication and failed to include specific individualized interventions related to Resident #1, #8, and #11's bowel patterns and the frequent use of as needed (PRN) medications.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 24 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional literature, and staff interview, the facility failed to monitor the effectiveness of an anticoagulant for 1 of 1 sampled resident (Resident #6) receiving Coumadin. Failure to perform PT (Prothrombin Time)/INR (International Normalized Ratio) lab tests may have resulted in adverse drug effects. Findings include: The Coagulation Service website, http://www.uab.edu/medicine/coag/patient-information: Blood Thinners, states, ". . . Coumadin is Dangerous and Hard to Control. Coumadin prevents a new clot from forming or an existing clot from growing. If a patient is taking too little Coumadin, it will not provide this protection and a new clot may form. Conversely, too much Coumadin causes bleeding, often severe enough to require hospitalization. . . . The Test. . . . One common use [of the PT/INR lab test] is to monitor the effectiveness of blood thinning drugs such as . . . Coumadin . . . The anti-coagulant drugs must be carefully monitored to maintain a balance between preventing clots and causing excessive bleeding. . . . doctor will check [the resident's] PT/INR regularly to make sure that [his] prescription is working properly . . ." Resident #6's medical record, reviewed September 23-26, 2013, identified diagnoses including atrial fibrillation, congestive heart failure,	F 281	F 281 PT/INR lab tracking 1. Resident #6's individual needs have been met by having the PT/INR drawn on 10-08-2013. MD informed and order given to continue the same dose and recheck in one month. Family informed of the lab vlaue and no change in the resident Coumadin. Intervention added to care plan informing staff that resident is on Coumadin and has the potential for blood clots and may bruise easily. 2. A list of resident with the diagnosis of HTN, A-Fib, and CHF and are on Coumadin have the potential to be affected in this area. The list of residents will be used to check PT/INR lab orders and if the residents PT/INR has been drawn per MD order, on the correct day, and if there is an order for a future draw and if it is on the calendar.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 25 and hypertension. The physician's telephone order and progress note, dated 12/05/12, identified, ". . . INR 1.8. Cont [continue] same Coumadin dose of 5 mg po [oral] qod [every other day] alternating [with] 2.5 mg po qod. Re[check] protime[/INR] in 1 month." An incident details report, dated 03/25/13, identified, "Protime (PT) should have been drawn in Jan. [January] did not get in new book - protime missed." The anticoagulant lab/therapy record identified the following: * 12/05/12, "INR Result 1.8 . . . Date of Next INR 1 month . . ." * 03/26/13, "INR Result 1.8 . . . Date of Next INR 1 month . . ." The facility failed to follow the physician's order and failed to recheck Resident #6's PT/INR level for 111 days (3 1/2 months). During an interview on 09/25/13 at 2:40 pm., a managerial health information staff member (#20) stated, "The clinic nurse calls us, and the lab, with the order [for the INR test]. The unit manager writes the telephone order, and then writes it on the lab sheet. She also writes it in the unit supervisor's book. I can't explain how that got missed. We document all over the place."	F 281	3. Nursing staff will be educated on 11-12-2013. Education will include the drug handbook reference on Coumadin which states routine monitoring of the law test PT/INR is required to be checked weekly for acute and up to annually for chronic conditions. System change: When a Coumadin order is received and entered into PCC the center will start to ask for the PT/INR lab value to be added to the physician order under supportive documentation requiring the lab value to be entered on the EMAR prior to administering Coumadin on Tuesdays. The time to administer the Coumadin will be changed from noon to 5 PM to allow time for the lab to process the order and for the center to follow up with the physician for an order changes.	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 26 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: 1. Based on record review, review of professional literature, and staff interviews, the facility failed to provide interventions to promote regular bowel elimination for 5 of 13 sampled residents (Resident #1, #7, #8 and #11) who required frequent as needed (PRN) interventions for constipation and 1 of 1 sampled resident (Resident #5) who required manual extraction of stool on four occasions. The facility failed to schedule and administer stool softeners/laxatives in a manner that stimulated bowel activity and prevented constipation (Resident #1, #7, #8, and #11) and four manual extractions (Resident #5) from occurring. Findings include: Berman, Snyder, Kozier, Erb, "Fundamentals of Nursing, Concepts Process, and Practice," 9th edition, Pearson Education, Inc., New Jersey, pages 1349-1350, stated, "Constipation may be defined as fewer than three bowel movements per week. This infers the passage of dry, hard stool or the passage of no stool. . . . Many causes and factors contribute to constipation. Among them are the following: Insufficient fiber intake, Insufficient fluid intake . . . Emotional disturbances such . . . mental confusion . . . Medications such as opioids [for pain] . . . Fecal impaction is a mass or collection of hardened feces in the folds of the rectum. Impaction results from prolonged retention and accumulation of	F 309	System Change: The unit supervisor will continue to use the GSS # 408 Anticoagulation lab therapy record to track PT/INR values until the center has completed the full transition to point click care. The GSS # 408 will be scanned into resident spaces at the end of the month. System change: The HIM will develop a spread sheet to track PT/INR's. She will ensure the order is placed on the calendar at each nurses station. Nursing will inform the MD and family of the current lab value and if any changes in the dose of Coumadin changed. 4. An audit will be developed to track all PT/INR labs, ensuring there is an order, is placed on the calendar for the next PT/INR lab drawn, and if the physician was informed of the value and change in coumadin. The DNS or designee will be responsible for the audit weekly for four weeks, then monthly for two months. The results of the audit will be reported to the QA committee for further recommendation. 5. 11-29-2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 27 fecal material. . . . Impaction can also be assessed by digital examination of the rectum, during which the hardened mass can often be palpated. . . . Along with fecal seepage and constipation . . . a general feeling of illness results . . . the abdomen becomes distended . . . The causes of fecal impaction are usually . . . constipation. . . ." Review of the facility policy titled "Bowel Assessment" occurred on 09/26/13. This policy, revised September 2010, stated, "Procedure: Assessment . . . establish elimination patterns, including times, volume, circumstances and frequencies of incontinent episodes . . . Establish the resident's own familiar terms and cues used for indication of a toileting need. . . . The Bowel Assessment . . . should be completed for residents who . . . have problems with elimination such as constipation or a history of impactions . . . The care plan interventions should be individualized based on the CAA [care area assessment] and modify the plan as appropriate based on an assessment of the resident's unique bowel elimination patterns. . . ." During an interview on the morning of 09/25/13, a managerial nursing staff member (#12) explained the facility's policy/procedure as follows, "After two days [without a BM], we would give the residents' the oral medications listed on their physician's orders. After three days, we would use a suppository. After four days, if they still can't push [have a bowel movement], we would do a rectal check, listen for bowel sounds, and give them an enema." "Nursing 2013 Drug Handbook," 33rd edition, Lippincott, Williams & Wilkins, Philadelphia,	F 309	F 309 Part 1 Bowel medications See also F 222, F 225, and F 280 1. Resident #5 expired on 10-22-2013. Resident #1's individual needs have been met by reviewing the bowel drug regimen with the physician. The physician increased the Senna two tabs BID. The kitchen provides 4 oz. of high fiber juice every morning with breakfast. The care plan updated as need for bowel care. Resident #7's individual needs have been met by reviewing the bowel drug regimen with the physician. The physician increasd the Senna to two tabs BID from one tab BID. The kitchen provides 4 oz. of high fiber juice every morning with breakfast. The Care plan updated as needed for bowel care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 28 pages 576-580, identified, "Fentanyl . . . CONTRAINDICATIONS & CAUTIONS . . . Drug may cause constipation. Assess bowel function and need for stool softeners and stimulant laxatives. . . ." - Resident #5's medical record, reviewed September 23-26, 2013, identified diagnoses including Alzheimer's dementia, pain, and constipation. The resident's quarterly Minimum Data Set (MDS), dated 07/27/13, identified problems with memory, moderately impaired daily decision making skills, extensive assistance of two persons for toileting, and use of scheduled and as needed pain medications. The record further identified the most recent bowel assessment had been completed on 06/26/08. The progress notes identified the following: * 05/05/13 at 6:00 a.m., ". . . Dulcolax Sup [suppository] given this a.m. for bowel regulation - BS [bowel sounds] hypoactive in [lower] quads [quadrants]. Only sm [small] BM [bowel movement] x [times] [one] documented since return from hosp [hospital] [on 05/02/13]" . . . at 12:00 p.m., "resident has trouble pushing to have BM - moderate amount to soft stool removed manually - bowel sounds noted today in all four quadrants of abdomen on auscultation with stethoscope . . ." * 05/12/13 at 10:30 a.m., "Resident on Day 4 [with] no BM - bowel sounds present in all four quadrants of abdomen on auscultation with stethoscope - rectal done and [sic] large amount of hard and soft formed stool felt - fleet enema given and poor results of no BM - [transferred Resident #5] to bed and digital stimulation with only small amount of stool removed [Nurse Practitioner] notified and orders received -	F 309	Resident #8's individual needs have been met by reviewing the bowel drug regimen with the physician. The physician increase ician orders have been updated to include a bowel protocol for PRN bowel medication including: No BM on day 2 provide MOM 30 cc, is not BM on day 3 days then provide a Dulc. Suppository one per rectum. If not BM on 4 days do a rectal check and listen to bowel sounds and provide a fleets enema for the resident. Nurses to assess bowel sounds and conduct a rectal check as needed to avoid an obstruction. The kitchen provides 4 oz. of high fiber juice every morning with breakfast. The Care plan has been updated as needed for bowel care. To avoid bruising due to too tight of legs the care plan was updated to have staff lay the resident down in bed for pericares, on her side, and perform pericare from the back. She has had no additional bruising since the survey. Resident #11 individual needs have been met by informing the physician of the constipation issues and use of PRN bowel medications. The MD increased	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 29 Dulcolax suppository given for bowel regulation. Resident has two large BMs of both formed and soft stool." * 05/17/13 at 7:00 p.m., ". . . fleet enema given and has large formed BM after . . ." * 05/23/13 at 1:00 p.m., "Abdomen appears distended moderately but soft - bowel sounds present in all four quadrants of abdomen on auscultation [with] stethoscope - Dulcolax suppository given for bowel regulation," and at 7:30 p.m., "Resident has moderate BM . . . has eaten poor the last two meals of today . . ." * 06/23/13 at 7:00 a.m., ". . . Dulcolax suppository this a.m. [with] only small constipated stool - laxatives given as ordered and fleet enema given [with] no results - small amount of blood tinged mucous noted from rectum - bowel sounds noted in all four quadrants of abdomen on auscultation [with] stethoscope." * 07/22/13 at 1:30 p.m., "Resident had dulc [Dulcolax] supp this a.m. [with] only small results. Bowel sounds very active in all four quadrant [sic]. Rectal [check] done [with] very little soft stool felt [up] high. Abdomen soft to touch. Will put her as one day BM list." * 08/05/13 at 8:00 a.m., "Resident on toilet - Had dulcolax suppository earlier and unable to push stool out - rectal alone and moderate amount of hard, formed stool removed [with] digital stimulation." * 08/10/13 at 11:30 a.m., "Resident on toilet [and] unable to expel form [sic] stool . . . Digital stimulation done [with] mod [moderate] results. Fleet enema given [with] lg [large] results." The documentation of Resident #5's eliminations (BM Report) between April 4, 2013-September 5, 2013 identified the resident failed to have a bowel movement for three days on five occasions, four	F 309	the Senna from one to two tabs BID and added PRN lactoluse. The kitchen provides 4 oz. of high fiber juice every morning with breakfast. The Care plan updated as needed for bowel care. 2. All residents' bowel records have been reviewed and any resident with a history of no BM in two to four days will have their bowel regimen reviewed by their primary care provider for recommendations and care plans will be updated. A nursing staff will be held on 11-12-2013 to educate the nursing staff on the procedure titled "Bowel Care". The nurses were educated on the Bowel protocol of: No BM in 2 days offer MOM 30 cc, No BM in 3 days offer a dulc suppository, if no BM in 4 days do a rectal check for BM and offer a fleets enema. 3. System change: All residents with a constipation issues identified by nursing are offered by dietary a high fiber foods, fruits, or juices from the kitchen. The kitchen would first offer prune or prune juice, but if the resident doesn't like prunes	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 30 days on five occasions, five days on one occasion, and nine days on one occasion. The physician's orders identified the following: * 06/28/08: Dulcolax Suppository 10 milligrams (mg) daily as needed for constipation * 06/08/08: Fleet Enema 7 grams (gm)/19 g daily as needed for constipation * 07/28/08: Milk of Magnesia 30 milliliter (ml) daily as needed for constipation * 09/22/09, Oxycodone 15 mg every two hours as needed for pain * 01/16/10, Oxycodone 40 mg twice daily for pain * 01/19/10, Fentanyl Patch 150 micrograms (mcg)/hour for pain * 03/05/13: Miralax 17 gm daily for constipation * 05/02/13: Dulcolax 5 mg 2 tabs daily as needed for constipation * 05/12/13: Senna S 50 mg/8.6 mg twice daily for constipation The medication administration record (MAR) identified the facility failed to schedule/administer stool softeners/laxatives in a manner that stimulated bowel activity and may have prevented constipation and four manual extractions from occurring. The current care plan identified, "Problem: Altered bowel elimination r/t [related to] constipation . . . Approaches: Medicate as ordered. . . . Offer high fiber foods, fruits, and juices in diet. . . ." The interdisciplinary assessments and summary review notes, dated 04/09/13, 05/13/13, and 07/31/13, all stated, ". . . We are to offer high fiber foods fruits [and] juices in diet along with encourage fluids r/t constipation. . . ." Review of	F 309	then they are provided 4 oz. of high fiber juice every morning. 3. System change: the night nurse will check the BM records and provide the day shift with a list of residents with no BM in two, three, or four days. The day nurse will follow the Bowel protocol drug regimen of: No BM in 2 days offer MOM 30 cc, No BM in 3 days offer a dulc suppository, if no BM in 4 days do a rectal check for BM and offer a fleets enema. 3 An audit tool will be developed to monitor the no BM reports. The report will indicate which residents have not had a BM on day 2, 3, or 4. If the bowel protocol for no BM's on days 2, 3, 4 was implemented, if dietary provided the 4 oz of high fiber juice with breakfast, if the appropriate medication was provided on the correct day without a BM and if the care plan addresses the constipation and the Bowel medication protocol for no BM. The DNS or designee is responsible for the completion of the audit. The audit results will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 31 the assessments indicated dietary staff were unaware of Resident #5's four manual extractions. During an interview on 09/26/13 at 11:55 a.m., a managerial dietary staff member (#9) reported Resident #5 received "prune juice at breakfast." She further stated, "She will drink prune juice." The facility failed to identify the specific dietary interventions (including prune juice) to be implemented in order to stimulate Resident #5's bowel activity and prevent constipation from occurring. The facility failed to assess and implement an individualized/specific plan of care for management of Resident #5's problem with constipation, including any revisions (i.e.: nutritional, fluids, physician directed changes to the resident's medication regimen, etc) following the above referenced episodes of fecal impaction, and lacked evidence of monitoring the effectiveness of an established plan in promoting normal bowel patterns/habits for Resident #5. - Resident #7's medical record, reviewed September 23-26, 2013, identified diagnoses including dementia, dehydration, and constipation. The resident's quarterly MDS, dated 08/19/13, identified moderately impaired cognitive skills and extensive assistance of two persons for toileting. The record further identified the most recent bowel assessment had been completed on 05/15/13. The only item checked on the assessment indicated Resident #7 was "continent." The documentation of Resident #7's eliminations (BM Report) between May 22, 2013-September	F 309	reported to the QA committee for further recommendations. Part 2 of F 309 see F 222, 225, and 280 mood and behavior. Part 3 of F309 bruising 1. Resident #2's individual needs have been met by changing the Ativan to be regularly scheduled. She is sleeping in her bed instead the Broda chair. Her care plan was reviewed to ensure the resident has a mood and behavior care plan problem has been updated to address her sleep, comfort, the addition of non pharmacological interventions, and adverse consequences including falls. The LPTA adjusted her wheelchair seat to prevent her from leaning or falling forward out of her wheelchair. She has not fallen from the wheel chair since this modification on 10-21-2013. Care plan has been updated to include non pharmacological interventions specifically sundowner's syndrome and verbal and physical abuse to staff. The care plan have been updated to include her current fall precaution interventions including a sensor matt to her bed and chair, he LPTA adjusted her wheelchair seat on 10-21-2013 to prevent her from leaning or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 32 15, 2013 identified the resident failed to have a bowel movement for three days on five occasions and four days on one occasion. The physician's orders identified the following: * 05/26/11: Bisacodyl Suppository 10 mg daily as needed for constipation * 05/26/11: Fleet Enema one bottle daily as needed for constipation * 05/26/11: Milk of Magnesia 30 ml as needed for constipation * 05/26/11: Senna one-to-two teaspoons as needed at hour of sleep for constipation * 09/10/11: Senna 50 mg/8.6 mg tab twice daily for constipation * 02/20/13: Colace 100 mg daily for constipation The medication administration record (MAR) identified the facility failed to schedule/administer stool softeners/laxatives in a manner that stimulated bowel activity and may have prevented constipation from occurring. The current care plan identified, "Problem: Potential altered bowel elimination: constipation . . . Approaches: Medicate as ordered. . . . Offer high fiber foods, fruits, and juices in diet. . . ." The facility failed to identify the specific dietary interventions to be implemented in order to stimulate Resident #7's bowel activity and prevent constipation from occurring. The facility failed to assess and implement effective interventions to Resident #7's plan of care following the above described episodes of constipation. - Review of Resident #1's medical record	F 309	falling forward out of her wheelchair and she has not fallen from the wheel chair since this modification. Resident #5 expired on 10-22-2013. 2. All residents that are incontinent of urine have the potential to be affect in this area. A list of frequently or total incontinence of the bladder will be generated and each will be reviewed for possible tight legs during pericare. If the residents has tight legs that prevents the staff from easy access to the periarea for clean then the resident will care plan and staff will be instructed to lie the resident down in bed, on their side, and provide pericares in bed as they tolerate to avoid bruises. 3. A nursing inservice will be held on 11-12-2013 to educate staff on the need to provide care in a safe manner for all affect residents. Some residents may benefit from adaptive clothing and staff needs to inform social services if any modification in clothing that may help. 4. An audit tool will be developed to monitor bowel movements and if staff are providing adequate pericare to frequently or totally incontinent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 33 occurred on all days of survey. Diagnoses included constipation and dementia. Medications included MOM, Dulcolax suppository, and a Fleets enema as needed (PRN) for constipation. The resident's quarterly MDS, dated 08/10/13 identified severely impaired cognition, required extensive assistance for toilet use, and continent of bowel and bladder. Resident #1's bowel assessment, dated 04/20/13 and completed by the nursing staff, identified suppositories (Dulcolax), laxatives (MOM), and enemas (Fleets) used PRN. Recommendations stated, "high fiber foods, fruits et [and] juices will be offered in diet." Review of Resident #1's nutrition progress notes failed to identify any concerns with constipation. Resident #1's current care plan stated, "Problem . . . Potential altered bowel elimination R/T [related to] constipation . . . Approaches: Medication as ordered. Monitor for adverse consequences. Encourage fluids. Offer high fiber foods, fruits and juices in diet." Review of Resident #1's BM reports and MARs from May through September 2013 showed the facility randomly administered a suppository and/or an enema before attempting a less invasive medication (MOM) on the following days: *05/09/13 - MOM and a Fleets enema administered on the same day with results. *05/31/13 - MOM and a suppository administered on the same day with results on the following day. * 06/14/13 - A Fleets enema administered with results. *The BM records identified the resident had a large BM on 07/08/13. The facility administered MOM on 07/09/13 even though the resident had a	F 309	residents without bruising or skin tears. The audit will be completed by the DNS or designee weekly for four weeks, then monthly times 2 months. The results of the audit will be reported to the QA committee for further recommendations. 5. 11-29-2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 34 BM the day before. *07/27/13 - MOM administered with results on 07/28/13, 6 days after the last BM (07/21/13). *08/01/13 and 08/04/13 - MOM administered with results on 08/07/13, 7 days after the last BM (07/30/13). *08/22/13 and 08/23/13 - a suppository administered on both days with results on 08/24/13. *09/01/13 - a suppository administered with medium results. *09/02/13 - small BM *09/04/13 - MOM and a suppository administered on the same day without results. *09/06/13 - MOM administered with results on 09/07/13. *09/16/13 - MOM administered with no results. *09/17/13 - a Fleets enema administered with results. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included constipation and dementia. Medications included MOM, Fleets enema, and a Dulcolax suppository PRN for constipation. The resident's annual MDS, dated 06/22/13, identified severely impaired cognition, required extensive to total assistance of one or more staff for toilet use and personal hygiene, and frequently incontinent of bowel and bladder. Review of Resident #8's bowel assessment, dated 09/20/13 and completed by the nursing staff, identified suppositories (Dulcolax), laxatives (MOM), and enemas (Fleets) used PRN. The assessment identified no further interventions. Resident #8's current care plan stated, "Problem . . . Potential altered bowel elimination R/T	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 35 constipation, H/O [history of] colon CA [cancer] . . . Approaches: Medicate as ordered. Monitor for adverse consequences. Encourage fluids. Offer high fiber foods, fruits & juices in diet." Review of Resident #8's BM records and MARs from May through September 2013 showed the facility randomly administered a suppository before attempting a less invasive medication (MOM) on the following days: *06/08/13 - a suppository administered with results. The record showed the last BM on 06/03/13, 5 days before the administration of the suppository, and no MOM given before the suppository. *06/11/13 - a suppository administered followed by 3 BMs. The record showed the last BM on 06/08/13 and no MOM given before the suppository. *06/16/13 - a suppository administered with large results. The record showed the last BM 06/13/13 and no MOM given before the suppository. *06/17/13 - MOM administered even though the resident had a suppository the day before with results. *06/18/13 - small BM *06/19/13 - a suppository administered (large results) even though the resident had a BM on the 16th and the 18th. *07/11/13- a suppository administered with large results. The record showed the last BM on 07/07/13, 4 days before the administration of the suppository, and no MOM given before the suppository. *07/19/13 - a suppository administered followed by 2 BMs. The record showed the last BM on 07/15/13 and no MOM given before the suppository. *07/20/13 - a suppository administered with	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 36	F 309		

results even though the resident had a suppository with results on the 19th.
*08/05/13 - MOM and a suppository administered on the same day followed by 3 BMs. The BM record showed the last BM on 08/02/13 and no MOM administered before the suppository.
*08/29/13 - a suppository administered followed by 2 BMs. The record showed the last BMs on 08/26/13 and no MOM administered before the suppository.
*09/09/13 - a suppository administered with results. The record showed the last BMs (3) on 09/06/13 and no MOM administered before the suppository.
*09/14/13 - MOM and a suppository administered on the same day with results. The record showed the last BM on 09/10/13, 4 days before the MOM and suppository were administered. The facility failed to administer the MOM and wait for results before administering the suppository.
*09/21/13 - a suppository administered with results on 09/22/13, the next day. The record showed the last BM on 09/18/13 and no MOM administered before the suppository.

- Review of Resident #11's medical record occurred on September 25-26, 2013. Diagnoses included Alzheimer's disease and constipation. Medications included MOM, Dulcolax suppository, and a Fleets enema PRN for constipation. The resident's quarterly MDS, dated 06/15/13, identified severely impaired cognition, required extensive assistance of one or more staff for toilet use and personal hygiene, and always incontinent of bowel and bladder.

Resident #11's current care plan stated, "Problem . . . altered bowel elimination, diarrhea vs [verses] constipation R/T Alzheimer's dementia . . .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 37 Approaches: Medicate as ordered. Offer high fiber foods, fruits & juices in diet." Review of Resident #11's BM reports and MARs from May through September 2013 showed the facility randomly administered a suppository before attempting a less invasive medication (MOM) on the following days: *05/05/13 - a suppository administered with results. The record showed the last on 05/01/13, 4 days before the suppository, and no MOM given before the suppository. *05/20/13 - a suppository administered followed by 2 BMs. The record showed the last BM on 05/17/13 and no MOM administered before the suppository. *05/26/13 - a suppository administered with results (MOM administered on 05/25/13). *05/27/13 - MOM and a suppository administered even though the record showed the resident had a BM on 05/26/13. The facility failed to administer the MOM and wait for results before administering the suppository. *06/21/13 - a suppository administered with results. The BM record showed the resident had a BM on the 17th, 18th, 19th, and 20th but the facility still administered a suppository (and no MOM) on the 21st. *06/24/13 - a suppository administered followed by 2 BMs. The record showed the last BM on 06/21/13 and no MOM given before the suppository. *06/27/13 - a suppository administered with results. The record showed the last BM on 06/24/13 and no MOM given before the suppository. *07/17/13 - a suppository administered with results. The record showed the last BM on 07/14/13 and no MOM given before the	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 38 suppository. *08/13/13 - a suppository administered with results. The record showed the last BM on 08/10/13 and no MOM given before the suppository. Failure to notify Resident #1, #5, #7, #8, and 11's physicians and the dietary department regarding their bowel habits and the possible addition of a daily stool softener/laxative and/or additional dietary interventions may have resulted in the residents' experiencing unnecessary discomfort and receiving invasive interventions (suppositories and/or enemas) for constipation. 2. Based on observation, 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 3 of 6 sampled resident (Residents #1, #2 and #5) identified with behaviors and on psychopharmacological medications. Failure to thoroughly assess the residents' behaviors, implement individualized interventions, including non-pharmacological interventions, and establish on-going monitoring of the behaviors resulted in decreased physical, mental, and psychosocial well-being and negatively impacted these residents' quality of life. Findings include: Review of the facility "Behavioral Causes and Interventions" policy occurred on 09/26/13. The policy, dated October 2009, stated: "Purpose: To aid in determining causes of behavior and appropriate intervention and strategies	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 39 Behavior Management Issues 1. Cognitively impaired residents who wander with no rational purpose, and are oblivious to needs or safety . . . may benefit from documentation to identify any trend or pattern to behavior. 2. Wandering is random or repetitive locomotion. This movement may be goal-directed . . . or may be non-goal-directed or aimless. Non-goal-directed wandering requires a response in a manner that addresses both safety issues and an evaluation to identify root causes to the degree possible. Moving about the facility aimlessly may indicate that cognitively impaired residents are frustrated, anxious, bored, hungry or depressed. 3. The behavior management team within the center should meet as soon as possible to discuss the resident's behavior and develop individualized interventions to minimize the risk of elopement. Consistent behavior documentation done by all three shifts identifies attempts at elopement as the target behavior, and allows for individualized interventions. Causal Factors of Behavior Try to determine what's causing the behavior. Is the behavior related to the resident's physical or emotional health? . . . environment? . . . communication? . . . tasks? . . . caregiver's approach? . . . Catastrophic Reactions . . . occurs when a situation is too overwhelming for a person with Alzheimer's/dementia, causing the person to react inappropriately. In order to effectively deal with the catastrophic reaction, it is important to analyze and identify the catalyst or underlying cause. Planning and programming should include attention to a resident as soon as there are signs that a catastrophic reaction may	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 40 occur such as agitation, increased restlessness, facial or body cues of fear or disorientation or distraught moods. Examples . . . Strategies For Addressing Aggressive Behaviors . . . 11. Hand the resident an item to hold while you provide care such as a softball, a soft stuffed animal or doll. 12. Consider wearing a long sleeved gown or shirt while providing care to residents who have a history of pinching or scratching during cares. . . ." Review of the "Documentation of Medication" policy occurred on 09/26/13. The policy, dated March 2011, included codes for "Non-pharmacological Interventions" attempted prior to administration of pain medications; and a "Code sheet for PRN [as needed] Antipsychotics" attempted prior to administration of anti-psychotic medications. - Review of Resident #2's medical record occurred on all days of survey. Resident #2's medical diagnoses included senile dementia, mood disorder, anxiety, and agitation. Resident #2's medication regimen identified orders for Ativan, an antianxiety medication, as follows: * 04/04/12: Ativan 0.5 mg (milligrams) to one mg by mouth every 4 hours as needed for anxiety; discontinued on 11/02/12 * 04/04/12: Ativan 0.5 mg one to two tablets by mouth every 6-8 hours; discontinued on 09/07/12 * 09/07/12: Ativan 0.5 mg to one mg intramuscularly every 4 to 6 hours as needed for agitation; discontinued 11/02/12	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 41 agitation; discontinued 11/02/12 On 11/02/12, a psychiatrist ordered Trazadone, an antidepressant, three times a day. A psychiatric progress note, dated 03/15/13, stated, ". . . I discontinued Trazadone 75 mg in the morning and 50 at noon, because she was way too sleepy. Now she has a little problem getting to sleep at night and they are asking if I can review her medication for 6:00 [p.m.]. . ." Physician progress notes dictated by Resident #2's primary physician included: an entry dated 07/01/13, ". . . does have problems with increased irritability and sundowning type symptoms usually into the late afternoon although today is having more problems earlier in the afternoon . . . wheeling herself around in her wheelchair. . . . restless and irritable . . . Dementia with behavioral disturbances, unchanged. . . ."; on 09/06/13: ". . . a bit more irritable at times particularly towards the late afternoon with staff just noticing more sundowning type behaviors. . . . Advanced dementia with sundowning . . . will be followed up by the psychiatry team for further assessment of mood and behavior issues. . . ." Observations of Resident #2 included the following: * 09/23/13 at 4:30 p.m.: Sitting, content, in her wheelchair in the activity room at a table with several visitors and another resident, celebrating that resident's birthday * 09/24/13 at 7:52 a.m.: Sitting in a recliner near a nurse's station asleep. * 09/24/13 at 9:00 a.m.: A certified nursing assistant (CNA) (#6), after assisting Resident #2 with toileting, stated the resident slept through breakfast; the CNA then transported the resident	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 42 * 09/24/13 at 10:15 a.m.: Observed in the "chapel." While five other residents sat around the table, Resident #2 slept in her wheelchair. * 09/24/13 at 10:35 a.m.: Remained asleep in the wheelchair. * 09/24/13 in the afternoon: A supervisory staff member (#2) stated Resident #2 never sleeps in her bed, as she would get out; stated the resident went to sleep at 3:30 a.m.; said when Resident #2 is awake she "can just go and go." * 09/24/13 between 2:30 p.m. and 2:50 p.m.: Resident #2 drank a nourishment drink at a desk outside of the nurse's station and then propelled her wheelchair into the nurse's station area. A nurse and CNA in the area visited with the resident with a calm approach; the resident held a comb and one of the staff members encouraged her to comb her hair. Neither staff member offered/provided Resident #2 with an activity to engage in. The staff members exited the nurse's station, and Resident #2 followed them part way out of the nurse's station area. At 3:30 p.m. the resident propelled herself back into the nurse's station, with the comb in her mouth, asking for help * 09/24/13 at 4:00 p.m.: In restorative therapy, Resident #2 told the therapist she wanted to go home. At 4:10 p.m. the resident sat at a desk outside of the nurse's station looking at papers. At 5:20 p.m. Resident #2 propelled her wheelchair over to the medication room door and knocked on the door. * 09/25/13 at 8:10 a.m.: Resident #2 fed herself breakfast in the dining room. At 10:55 a.m. the resident sat, asleep, in her wheelchair next to the nurse's station. * 09/26/13 at 7:30 a.m.: Resident #2 sat in a recliner next to the nurse's station asleep. At 8:10 a.m., Resident #2 sat in her wheelchair asleep. At	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 43	F 309		

9:45 a.m., Resident #2 continued to sleep in the area just outside of the nurse's station in her wheelchair, with a blanket over her. At 11:30 a.m., Resident #2 continued to sleep in this area. At noon, the resident, while sitting in her wheelchair, slept at the dinner table.

A quarterly Minimum Data Set (MDS), dated 08/31/13, and an annual MDS, dated 03/02/13, identified Resident #2 wandered 4 to 6 times a day, but less than daily. Both MDSs identified this as no change in behavior symptoms; identified Resident #2 with short and long term memory problems; as moderately to severely impaired in daily decision making, and as able to make herself understood and able to understand others.

A comprehensive assessment for the annual MDS, dated 03/02/13, identified the following care areas triggered:
* Communication: ". . . is confused d/t [due to] Dx [diagnosis] Dmentia [sic], such that communication is at times not effective. She is alert and able to verbalize. Hearing and vision are not limiting factors. . . . cognition deficits as expected with advanced dementia. She is also restless. Her confusion has been long standing. She continues to require meds [medication] for restlessness, and has varying mood tones from pleasant to aggitiated [sic]. She is not showing s/s [signs or symptoms] of adverse side effects. She is on multiple psychotropic with adjustment [sic] so is at risk for adverse side effects."
* Mood State: ". . . was sleeping the times I attempted to complete my assessments, she has periods where she is sleeping heavily and then will be awake for a long period of time. When she is awake she will propel her wheelchair by herself

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 44 around the facility. . . ." * Psychotropic Drug Use: ". . . Resident is on psychoactive medications for her mood and behavior issues. She has mood disorder requiring treatment. . . . Adverse consequences . . . Sedation . . . drowsiness, little/no activity involvement . . . Resident is at risk for falls due to cognition and physical function deficits . . . can be very restless at times. . . ." * Falls: " . . . She does at times wander about in her wheelchair but is generally situated at nurse's station for close supervision. She prefers to be around people. She also becomes restless at times. . . ." Resident #2's current care plan identified the following problems: * "Impaired mobility and potential for falls r/t dementia . . ." with approaches of "Will not sleep in bed. . . ." * "Alteration in mood/behaviors r/t [related to] dementia, insomnia, anxiety/agitation, sundowners m/b [manifested by] confusion, restlessness, currently on psychoactive meds [medications], behaviors: verbal, physical and resisting cares with a goal of being free from adverse side effects of psychoactive medication [and] will be free from increased s/s [signs and symptoms] of anxiety and depression. Approaches included monitoring Resident #2's sleep patterns nightly, "Observe/report changes in mood/behavior, Mental Health Referral as needed, Medicate as ordered, monitor for for [sic] adverse consequences, Observe/report s/s anxiety; easily annoyed, irritable, tired, worried, restless, startles easy." The care plan did not provide approaches for the identified verbal, physical, resistance to cares and wandering behavioral symptoms. The care plan also failed to	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 45 address these behaviors. * "Dependent on others for all leisure needs r/t cognitive status m/b short attention span, Limited interest in leisure activity, memory problems . . . enjoys visiting . . . likes to hold stuffed animals, etc. Has rummage items, needs cues prompts and assistance but may refuse the help" with approaches including " . . . assist, encourage and record activities . . . invite and assist to center activities . . . provide small group activities . . . provide close supervision and redirection when restless, as able, provide stuffed animal or doll to hold as may find comfort in these items, provide items to sort or fold . . ." "Behavior Documentation Notes" (logged into a behavior documentation binder, completed primarily by direct care staff) between 10/15/12 and 08/27/13 included the following staff responses to Resident #2's behavior: * 10/04/12 ". . . very restless. She will not stay seated in her wheelchair or in bed or the recliner. When staff asks resident what is wrong, she starts crying and won't talk. . . ." * 10/09/12 at noon, ". . . Resident was told that the behavior was inappropriate. . . ." * 10/13/12 in morning, ". . . can not be redirected. . . ." * 10/14/12 in morning, ". . . slightly combative at times when trying to redirect." * 10/15/12 ". . . CNA told the resident it was inappropriate behavior . . ." * 10/24/12 at 9:30 a.m., "Resident was going into another resident's room. CNAs told resident that was not her room and tried directing the resident a different direction so CNAs could take the other resident to the bathroom. . . ." This resulted in Resident #2 becoming aggressive with the staff. * 10/27/12, ".. . .restless . . . tried redirecting	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 46 resident but nothing keeps her occupied long enough. . . ." * 11/16/12, "When CNAs went to toilet resident she was very short tempered. Yelling and saying "I'm going to shoot up [sic] . . . CNA said 'that ain't nice.' . . ." * 11/22/12 and 11/23/12 during the night shift, ". . . She was digging in all the drawers in the nurses station and when I asked her to please not dig in them she told me this was her . . . stuff . . . I told her that it wasn't very nice to talk to someone like that . . . Then she came up to me & started telling me she wants to go to her car and she needs to go home. . . ." * 11/25/12, ". . . Noc [night] nurse reported she did not sleep last noc. . . ." * 11/28/12, ". . . slept for less than 2 hours. . . . was digging in drawers & when I asked not to she [swore]. . ." * 12/15/12 at 7:00 a.m., "Res had fallen asleep for an hour or so earlier. She suddenly awoke and tried to climb out of bed. . . . I finally had to use a firm tone of voice/scolding Res. . . ." * 08/27/13 at 9:00 p.m., "Resident entered new residents room tonight & proceeded to tell her to get out . . . Reassurance given to new resident." The "Behavior Documentation Notes" identified no documented behaviors within an eight month period between December 2012 and August 2013. Review of the above identified staff approaches consisted of reprimanding Resident #2, insisting she remain in bed or her wheelchair, and redirection. Specific approaches for redirection were not recognized nor developed. The facility also failed to put measures in place for Resident #2's wandering behavior as identified with her intrusion into other resident's rooms on at least	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 47 two occasion. Staff administered Lorazepam/Ativan (anti-anxiety drug) orally (po) or intramuscularly (IM - injection) at various times of the day beginning on 09/27/12 and at least once or twice daily throughout the month of October for behaviors. Several of the behaviors were related to the resident's attempts to get out of her chair or bed, restlessness, or failure to sleep during the night. The record lacked evidence staff attempted non-pharmacological interventions prior to medicating Resident #2 with the anti-anxiety medication. The record included: * On 09/27/12 at 7:30 a.m. a nurse gave Resident #2 Lorazepam "for anxiety, agitation" with short-term relief. * 09/28/12 at 6:00 a.m., "Resident was restless and anxious, PRN [as needed] ativan IM was given at 9:00 p.m. Resident was awake in bed, trying to climb out of bed. There was no relief for the 9 PM PRN ativan. At 1:00 a.m. PRN IM 0.5 [mg] was given with relief. Resident is sleeping comfortably. . . ." * 09/29/12 at 3:00 a.m., "Resident has been restless tonight. Medicated [with] ativan et [and] it has not been effective. Res. [resident] is up in w/c [wheelchair] now and is crying and restless. . . ." * 09/30/12 at 1:00 a.m., "Resident has been crying et anxious throughout shift, also restless, does not sit still. Ativan po et IM given per orders, it is not effective . . . Resident was crying stating 'I'm scared' et pounding on the wall; redirection is difficult as res. has very short attention span." * 10/01/12 at 5:05 a.m., ". . . restless during shift. Does not sit still. Was in w/c at nurse's station for much of the night. Ativan po & IM given. . . . Was not very effective. Redirection not effective due to short attention span. Also seemed to agitate her	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 48 at times." * 10/02/12 at 3:30 a.m., ". . . placed in recliner. . . restless during first part of shift. Would self propel self in w/c around nurse's station becomes very anxious. Medicated x 2 [two times] [with] PRN ativan as directed. Resident has been sleeping since." * On 10/04/12 between 3:00 p.m. and 10:00 p.m., nursing staff "Medicated x 2 for anxiety." * On 10/05/12 at 3:50 p.m., Resident #2 scooted out of her wheelchair. Refer to F 323 regarding fall. * On 10/06/12 at 7:15 a.m., nursing staff administered Resident PRN ativan IM for being "anxious and restless early in the shift. . . ." * On 10/19/12 at 3:15 p.m. nursing staff administered the Lorazepam as resident . . . very anxious and restless this a.m. Trying to get out of w/c [wheelchair]. Nurse administered 1 mg [milligram] Ativan 7:20 [a.m.]" * 10/20/12 between 2:00 p.m. and 4:45 p.m., nursing staff administered "Medication" for Resident #2's restlessness and trying to get out of her chair. At 4:35 p.m., "Resident was found on the floor face down." A report identified nursing staff administered Ativan one mg IM within the four hours prior to the fall. * On 10/25/12, a nursing staff member faxed a psychiatrist, "[primary care physician-PCP] has prescription for Lorazepam for [Resident #2] - as Resident is given the PRN (po) dose 1-3 x daily & we use IM Ativan also - [the PCP] wants you to prescribe the Lorazepam . . ." * On 11/01/12, Resident #2's PCP discontinued the oral and IM orders for Ativan and the psychiatrist, per a telephone order, ordered Trazadone (anti-depressant). Interdisciplinary Progress Notes (IDPN), between	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 49	F 309		

11/16/12 and 11/26/12 included six entries regarding Resident #2 not sleeping at night. The notes included, ". . . Noc [night] nurses report that she does not go to sleep until around 0100 [1:00 a.m.]. . . Noc nurse reported res. slept a 'few' hours last noc . . . Night nurse reported [Resident #2] 'up all noc' . . . Hollering from 7 p.m. till midnight. Slept from 12 [midnight] - 3 A [a.m.] . . ."

IDPN, dated 11/26/12 at 5:50 p.m. stated, "Return call from [psychiatrist] re [regarding] insomnia/anxiety give Haldol (an anti-psychotic medication) 5 mg po at hs [bedtime] tomorrow (11/27) . . . Call [psychiatrist] in AM of 11/28 to report effect on sleep - Then [check] after 11/27 give Haldol 5 mg po daily at hs PRN insomnia/anxiety." The IDPN notes identified that on the night of 11/28 (after 11/27 dose of Haldol) "resident was awake almost all night. - [psychiatrist] office contacted & updated. On the morning of 11/29/12 (after Resident #2 received two consecutive doses of Haldol), nursing wrote, ". . . she only slept 1-1 1/2 [one to one and a half hours] all night." A nursing staff member contacted the psychiatrist's office and Seroquel (an anti-psychotic) 100 mg once per day PRN was ordered, and the psychiatrist discontinued the Haldol. Following one dose of Seroquel, the psychiatrist discontinued the medication as "Nursing staff reported since she had taken the new order for Seroquel - noted she was having tremors. . . ."

* IDPN, dated 02/20/13 and 08/02/13, each identified a fall Resident #2 sustained while "asleep" or "sleeping" in her wheelchair.

During interview on 09/25/13 at 9:10 a.m., a supervisory staff nurse (#2) stated CNAs are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 50	F 309		

informed of cares for residents through a "group list" which identifies "briefly" what the expectation is for CNAs regarding cares. Review of the list did not identify any approaches for staff to utilize when dealing with Resident #2's behaviors and moods.

During interview on 09/26/13 at 9:00 a.m., a social services staff member (#7) stated nursing staff cannot "contain" Resident #2. The staff member stated she did not know if there is a known cause for Resident #2's behaviors. The staff member stated she had not correlated Resident #2's falls with behavior management currently in place (i.e. medication administration). The staff member stated that to obtain information on the resident's behavior, direct care staff are interviewed for completion of the MDS. The staff member agreed the facility needs to address behaviors, including causative factors, to individualize approaches/ alternatives prior to administrating medications for sleep, insomnia, anxiety, and restlessness.

The facility failed to assess, including determining causative factors, implement measures, and evaluate those measures for effectiveness in regards to Resident #2's behaviors. This resulted in nursing staff failing to address these behaviors before utilizing medications for these symptoms.

- Resident #5's medical record, reviewed September 23-26, 2013, identified diagnoses including Alzheimer's dementia, anxiety, and pain. The resident's quarterly MDS, dated 07/27/13, identified problems with memory, moderately impaired daily decision making skills, extensive assistance for activities of daily living (ADLs), and use of scheduled and as needed pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 51	F 309		

medications. The antipsychotic Care Area Assessment (CAA), dated 05/09/13, further identified, ". . . The prn ativan dose was recently decreased due to too sedating. . . . On 05/07/13 the ativan dose was again increased. . . ."

The current care plan identified, "Problem: Alteration in mood/behaviors r/t dementia, delusiona [sic] disorder . . . Altered comfort . . . Approaches: Medicate as ordered. . . . Provide non-drug pain relief . . . ."

The physician's orders identified the following:
* 07/11/12, Lexapro 10 mg daily at hour of sleep for anxiety
* 01/19/13, Fentanyl Patch 150 mcg every hour for pain
* 02/20/13, Risperdal 0.25 mg twice daily for delusions
* 05/02/13, Oxycodone 15 mg every two hours as needed for pain
* 05/08/13, Ativan 0.5 mg every four hours as needed for agitation/restlessness
* 05/16/13, Tylenol 650 mg three times daily for pain

The progress notes identified the following:
* 04/27/13 at 2:00 a.m., ". . . Res attempting to self stand . . . [medicated] [with] oxycodone . . . as well as ativan . . ."
* 05/02/13 at 2:15 p.m., ". . . safety concerns as she does not remember she can't get up alone [and] is unaware of her safety deficits. . . ."
* 05/03/13 at 6:35 a.m., "Agitated early on in shift - did not want to stay in bed - didn't seem to comprehend that it was her usual time that she goes to bed - ativan . . . given with good results - was much more relaxed [and] then settled into sleep - slept well [after] wards without complaints

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 52 or trying to get [up] out of bed." * 05/06/13 at 3:30 p.m., "Ativan . . . given for restlessness, will not stay in bed . . ." * 05/07/13 at 1:30 p.m., ". . . Resident was laid down to rest but did not stay there very long. Was given ativan . . ." * 05/08/13 at 7:45 a.m., "Resident was restless on evenings . . . I had CNAs lay her back in her bed, she did sleep til [until] about 4:30 a.m. and started climbing out of bed again," at 10:00 a.m., ". . order received . . . increased ativan . . . prn for increased agitation/restlessness," and at 10:30 a.m., "Resident remains restless Ativan . . . given." * 05/15/13 at 1:00 p.m., "Resident very restless CNA attempted to lay resident down but she kept getting out of bed so they put her back in her w/c," and at 1:30 p.m. "Ativan . . . given for anxiety/restlessness [and] laid back down . . . resident did stay in bed at this time." * 05/16/13 at 12:00 p.m., "restless not wanting to stay in her w/c - ativan . . . given" * 05/18/13, "Resident . . . attempting to get out of her w/c ativan [given] . . ." * 05/19/13 at 8:00 a.m., "Medicated [with] oxycodone . . . to prevent pain . . . Also given ativan . . . as resident restless." * 05/22/13 at 1:30 p.m., ". . . restless staff attempted several times to lay back down but resident attempted to get out of bed - staff got her up in w/c," and at 2:30 p.m., "medicated [with] oxycodone . . . [and] ativan . . ." * 05/26/13 at 7:00 p.m., ". . . was very restless [and] agitated at HS, resisting staff's attempts at helping her get ready for bed was given . . . ativan . . . which was effective." * 05/31/13 at 9:30 p.m., "Resident very agitated, attempting to get [up] out of bed . . . was given ativan . . . [with] good results."	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 53 * 06/04/13 at 12:30 p.m., "Resident very anxious refusing to sit in her w/c staff unable to get her to sit down - ativan . . . given," and at 2:00 p.m., "Resident resting quietly in bed." * 07/06/13 at 1:30 p.m., "Resident restless - keeps standing up out of w/c . . . ativan given . . ." * 07/22/13 at 7:00 a.m., "Resident has been restless and agitated all day. Has received ativan . . . [and] oxycodone . . ." * 08/05/13 at 1:00 a.m., "Resident very restless tonight. Was given ativan . . . with little effect. Patient continues to attempt to get out of bed. . . ." * 08/16/13 at 3:30 p.m., "Resident very anxious, agitated, medicated [with] oxycodone . . . [and] ativan which did not help kept resident [at] desk [and] busy otherwise she cont [continued] to attempt to get out of w/c." The facility failed to attempt non-pharmacological interventions prior to administrating anti-anxiety medications. During two interviews on 09/25/13 at 11:15 a.m. and 11:30 a.m., a managerial nursing staff member (#15) stated, "We don't chart the interventions attempted prior to passing a med [medication]." She further stated, "If the resident has chronic pain, we give the pain med first, and the anxiety med later. We would check [the resident's] pain level one hour later. If the resident isn't settled down, then we give the anxiety med." The medication administration record (MAR) identified facility staff administered oxycodone and ativan 0-20 minutes apart as follows: * April: 7 days * May: 10 days * June: 3 days	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 54 * July: 4 days * August: 7 days * September: 4 days The facility failed to reassess Resident #5's pain level prior to administrating anti-anxiety medications. Failure of the facility to assess the precipitating factors (i.e.: pain, constipation, need to use the bathroom, inability to communicate, caregiver's approach) leading up to/resulting in Resident #5's attempts to rise from her bed/chair, and develop/implement effective interventions placed the resident at risk of being over-medicated and/or of falls/injuries. Failure of the facility to assess (i.e.: nonverbal/verbal signs/symptoms) and manage Resident #5's pain may have resulted in the resident receiving both Oxycodone (an narcotic pain medication) and Ativan (an anti-anxiety medication) at the same time, without the opportunity to determine if Oxycodone alone may have been effective in stopping/controlling her behavior. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included senile dementia and anxiety. Medications included Ativan 0.5 mg every morning and every 8 hours PRN and Remeron (antidepressant) 15 mg daily. Resident #1's current care plan stated, "Problem . . . Alteration in mood/behaviors R/T [related to] anxiety, senile dementia with delusional features . . . medicate as ordered . . . observe/report S/S [signs or symptoms] anxiety: easily annoyed, irritable, tired, worried, restless, startles easily." Review of Resident #1's progress notes and MAR	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 55 identified the following: *05/12/13 - A progress note stated, "Had one crying spell. Was very confused and ask [sic] about her mother and father and brother. Nurse told her they passed away years ago. Gave resident Ativan to calm her at this point at 1600 [4:00 p.m.] . . . *05/18/13 - The MAR showed PRN ativan administered for "restless/agitation." The progress notes failed to identify any behavioral concerns on this day. *05/19/13 - A progress note stated, ". . . Resident medicated [with] Tramadol [pain medication] . . . @ [at] 1230 [12:30 p.m.] for upset stomach pain was 4/10 [4 out of 10: "0" indicates no pain and "10" indicates the worst pain]. Tramadol effective . . . also medicated @ 1230 [with] Ativan . . . as Resident restless. Ativan . . . also was effective . . ." Facility staff failed to allow time for the pain medication to take effect before they administered Ativan for "restless." *05/20/13 - A progress note at 6:00 p.m. stated, "Resident resisting help with feeding. Refused meds [medications]. Tried several times today to get them down. Nurse states she needed the meds for her heart and memory. Resident state 'No just let me die.' Nurse tried to persuade her the second time. She stated 'Just let the Lord take me home. I feel sick. like I am going to vomit.' Nurse did not try to persuade her further because she started to gag. Instructed CNAs to let her eat what she wanted, not to force her." The MAR showed PRN Ativan administered for "agitation." *05/28/13 - A progress note stated, ". . . [no] crying or [increased] anxiety today . . ." The MAR showed PRN Ativan administered for "restlessness."	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 56 *05/29/13 - The MAR showed PRN Ativan administered for "restless, irritable, anxious." The progress notes failed to identify any behavioral concerns on this day. *05/31/13 - The MAR showed PRN Ativan administered for "restlessness/anxiety." The progress notes failed to identify any behavioral concerns on this day. *06/04/13 - The MAR showed PRN Ativan administered for "agitation." The progress notes failed to identify any behavioral concerns on this day. Failure to identify possible causative factors which precipitated behaviors does not allow the facility to determine patterns in Resident #1, #2, and #5's behavior or develop and implement creative individualized interventions to decrease the behaviors. 3. Based on record review and staff interview, the facility failed to provide the necessary care and services to prevent injury for 1 of 13 sampled resident (Resident #8) with an injury related to cares provided. Failure to ensure staff provided care in a safe manner may affect all residents. Findings include: Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia. Medications included aspirin 81 milligrams (mg) daily. Resident #8's annual Minimum Data Set (MDS), dated 06/22/13, identified long and short term memory problems, and required extensive to total assistance of one or more staff members for	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 309	Continued From page 57 transfers, dressing, and personal hygiene. The current care stated, "Alt. [alteration] [in] Bladder elimination . . . Check, change, reposition every 2-3 hours." A progress note, dated 06/20/13 at 9:30 p.m., stated, "2 bruises noted [left] inner thigh [Resident #8] . . ." An incident report, dated 06/20/13, stated, ". . . 2 bruises noted to [left] inner thigh area . . .1) 2 cm [centimeters] round purple 2) 1 cm long purple/red . . . . What immediate interventions have been put in place to prevent this incident from happening again? Remind cnas [certified nursing assistants] et [and] staff not to pull thighs apart hard while changing her briefs ? ? [question mark, question mark] . . . Summarize factors that may have contributed to this incident: Pulling thighs apart too aggressively while changing her brief ? . . . Results of investigation: 6/24/13 I'm sure the bruises happened when staff changed her brief. [Resident name] is strong and is hard to remove the brief. She bruises easily. Staff was instructed to be more careful . . ." The report failed to identify the type of education/instruction the direct care staff received. The facility failed to provide caregivers an alternative way to provide incontinence cares for Resident #8. This may result in additional incidents of bruising during cares.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 314	Continued From page 58 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment and services to prevent the occurrence of a facility acquired pressure ulcer for 1 of 1 sampled resident (Resident #7) with a deep tissue injury (DTI) and promote the healing of a pressure ulcer for 1 of 1 sampled resident (Resident #9) with a current pressure ulcer. Failure to provide timely and appropriate interventions and ensure staff consistently implemented existing interventions contributed to the development of Resident #7's new pressure ulcer and has the potential for the deterioration of Resident #9's existing pressure ulcer and the development of additional pressure ulcers. Findings include: Review of the facility policy titled "Pressure Ulcers" occurred on 09/26/13. This policy, revised March 2007, stated, "Policy: . . . a resident entering the center without pressure ulcers does not develop a pressure ulcer unless the individual's clinical condition demonstrates that this was unavoidable. A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing . . . Ongoing Skin	F 314	F 314 1. Resident # 7's individual needs will be met by reassessing the left heel wound and documenting on the wound care flow sheet. Current measures indicate the deep tissue injury is healing evidenced by the fact that the wound is smaller in size. Increased protein has been added to the diet and the tight stockings have been removed from the room. The care plan has been updated. Resident #9 expired on 10-22-2013. 2. All residents with a Braden score of 17 or higher have the potential to be affected in this area and are at high risk for developing a pressure ulcer been generated and all of these residents have had their skin checked for any red areas or unusual marks. None were found.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 314	Continued From page 59 Assessments: Residents at risk for pressure ulcer development and those with pressure ulcers/wounds should be monitored daily for changes in their skin condition. This may occur during the course of the resident's daily care and/or bathing where the CNA should perform a head to toe check of the resident's skin, paying particular attention to: *The surfaces of the skin that come in contact with the bed and chair *Bony promihences (heels . . .) . . . Definitions: . . . *"Suspected Deep Tissue Injury" - Purple or maroon localized [unstageable] area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue . . ." Review of the facility policy and procedure titled "Pressure Ulcers: Skin Assessment and Prevention" occurred on 09/26/13. This policy, revised 01/12, stated: ". . . 1. All residents will be identified for their risk of developing pressure ulcers on admission/readmission . . . using the Braden Scale for Predicting Pressure Sore Risk . . . 2. The registered nurse will complete the Braden Scale for Predicting Pressure Sore Risk . . . on all residents quarterly or when the resident has a change in condition which could affect their risk of developing an ulcer . . . 14. The pressure ulcer should be assessed/evaluated at least weekly and documented on the Wound Flow Sheet . . . with every treatment change. Observation of the ulcer's characteristics may be documented by a licensed nurse and should include at least the following: *Measurements - length, width, depth	F 314	3. All nursing staff was educated 11-12-2013 on the procedure titled: "Pressure Ulcers" with a focus of the education on the need for staff to inspecting skin during routine cares, reporting unusual marks or complaints of pain to the charge nurse, the need to float resident heels, pressure points on the body, pressure reduction and relieve products, and the importance of preventing pressure ulcers. Licensed staff is expected to document daily on all open pressure ulcers and suspected deep tissue injuries. 4. An audit will be developed to monitor daily documentation of open wounds. The audit will be complete 3-5 times per week for 4 weeks, then weekly for two months. The audit will be completed by one nurse and two CNA's on each shift for at least two residents. The DNS or designee is responsible to ensure the audits are completed and analysis. The audit results will be reported by to the QA committee for further recommendations. 5. 11-29-2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 314	Continued From page 60 *Characteristics of the ulcer . . . *Presence of pain *Current treatments . . ." - Resident #7's medical record, reviewed September 23-26, 2013, identified diagnoses including dementia, fatigue, and history of venous stasis ulcer. The resident's quarterly Minimum Data Set (MDS), dated 08/19/13, identified moderately impaired cognitive skills and extensive assistance for bed mobility, transfers, locomotion, and toileting. The MDS further identified Resident #7 as at risk of developing pressure ulcers, and listed the following skin/ulcer treatments: pressure reducing device for bed/chair and applications of ointments/medications. The Braden Scale for Predicting Pressure Sore Risk, dated 08/19/13, identified, ". . . Total Score 19 [Not at risk of developing a pressure ulcer] . . ." A progress note, dated 09/22/13 at 8:00 p.m., stated, "CNAs [certified nurse assistants] helped [Resident #7] to bed, notified me of discoloration left heel. She has a 2.5 x 4.5 cm [centimeter] purple area on heel, suspected deep tissue injury. Tissue intact, firm, painful. Will place heel lift boot to be worn at all times until resolved." During interview on 09/25/13 at 1:00 p.m., when asked for assistance locating the wound flow sheet, a managerial nurse (#12) stated, "Oh, there is no wound flow sheet for her. Usually the nurse who first sees it writes one up. Facility staff failed to locate the wound flow sheet in Resident #7's chart.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 314	Continued From page 61 During an interview on the morning of 09/26/13, when asked for assistance locating the wound flow sheet, an administrative nurse (#3) located the sheet in her office. The wound flow sheet, dated 09/22/12 at 8:00 p.m., further identified, ". . . Location: . . . Heel L [left] . . . Length: 2.5 cm, Width: 4.5 cm . . . Drainage Amount: None . . . Surrounding Skin: Intact, Undermining/Tunneling: Unknown, Odor: No, Pain: Yes . . ." During an interview on 09/24/13 at 11:10 a.m., when asked if her heel causes her pain, Resident #7 stated, "It's especially painful in the morning when I get up." When asked when she first began experiencing pain in her heel, she stated, "It's been hurting for some time now." She reported experiencing pain prior to staff discovering the wound on her heel. During an interview on 09/25/13 at 8:53 a.m., when asked to explain the procedure for the daily skin checks, a Bath Aide (#21) stated, "I check everything . . . bottom, heels. If I find something, I tell the nurse. If the resident is on the skin sheet, the nurse will check too." During an interview on 09/25/13 at 1:10 p.m., when asked to explain the procedure for the daily skin checks, a CNA (#16) stated, "If the CNA knows their resident, they should know if they [the resident] have an ulcer or [skin] tear. We check during common ADLs [Activities of Daily Living] . . . grooming, dressing . . . We report anything new to the RN [Registered Nurse]." During an interview on 09/24/13 at 3:40 p.m., when asked why the wound on Resident #7's heel	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 314	Continued From page 62	F 314		

had not been identified prior to it measuring 2.5 cm by 4.5 cm in diameter, a managerial nurse (#18) stated, "It looked like a bruise with black, intact skin . . . firm to the touch. It is a deep tissue injury . . . an ulcer. You'd have to hit your foot pretty hard to get a bruise that color. I assume it was there prior . . . on the previous shift . . . the previous day. I'm not sure why the CNAs didn't see it while they were bathing and dressing the resident."

A progress note, dated 09/23/13, stated, "PTA [Physical Therapy Aide] Heel lift suspension boot to be worn on (L) [left] foot when supine lying in bed. May use blue heel protector when in w/c [wheelchair] to (L) foot. . . . PTA [and] Nsg [Nursing] conferenced regarding (L) heel deep tissue injury. RA [Restorative Aide] program q [every] ambulation will be placed on hold until DTI [deep tissue injury] is healed. Will update care plan."

The current care plan, dated 08/29/13, identified, "Problem: Potential impaired skin integrity . . . Approaches: Pressure relief mattress and chair pad, Bed mobility and repositioning every 2 hrs [hours] or more frequently with assist of 1-2, No massage of reddened boney [sic] prominences, Replace protein to meet daily requirements, Daily skin checks. Report to nurse any red, open, irritated areas daily, Weekly skin evaluations on Thursday, Use lift sheet to move resident if needed to prevent friction and sheer. . . . Problem: Impaired mobility . . . Approaches: . . . Ambulate . . . Hold 09/23/13 [secondary] DTI on (L) heel. . . . Heel lift suspension boot to (L) heel when resident supine lying. Blue heel protector when in w/c."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 314	Continued From page 63 The short-term pressure ulcer care plan, dated 09/22/13, identified, "Problem: . . . left heel suspected DTI . . . Approaches: . . . 2. Monitor status of ulcer, surrounding skin and dressing, 3. Document size and progress on the Wound Flow Sheet . . . 5. Provide support surfaces as appropriate . . . heel lift boot, 6. Monitor for pain; provide non-pharmacological interventions and/or medications/treatments as ordered . . . 8. Notify Dietary for interventions as appropriate . . ." The [undated] nutritional risk notification form identified, ". . . New pressure ulcer . . . Comments: Replace protein not taken in meals, provide sufficient protein to meet healing requirements. . . ." The Treatment Record, dated September 2013, identified the following: * Pressure ulcer documentation of skin assessment flow sheet weekly on Fri [Fridays] by DON [Director of Nursing]. * Daily monitoring and documentation of left heel suspected deep tissue injury. 1. Evaluation of the ulcer if no dressing daily. [Staff initialed the treatment record on September 22-24, 2013.] 2. Evaluation of status of dressing daily. 3. Status of area surrounding the ulcer daily. 4. Presence of possible complications daily. 5. If pain is present and adequately controlled. Open to air. See reverse side of wound care sheet for documentation of changes, problems, progress towards healing. *Heel lift boot to left foot at all times until injury resolved. [Staff initialed the treatment record on September 23-24, 2013.]	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 314	Continued From page 64 Observations showed the following: * On 09/23/13 at 4:10 p.m. and 09/24/13 at 8:00 a.m. and 12:25 p.m., Resident #7 sat in her wheelchair with a blue heel protector on her left foot. * On 09/23/13 at 4:22 p.m., an unidentified nursing staff member stated, "[Staff] found a blister on her [Resident #7's] heel. She did something to it." * On 09/24/13 at 10:45 a.m., a managerial nurse (#12) assessed the wound on Resident #7's left heel. The managerial nurse (#12) described the wound as "deep purple[/black]" in color, with a "dry, intact" surface and "no drainage." She estimated the wound to be "close [to] 2.5 cm by 4.2 cm" in diameter. She further stated the cause of the injury was unknown as the resident does not self transfer and wears socks and shoes. Prior to leaving Resident #7's room the nurse requested the CNA [Certified Nurse Assistant] obtain another sock for the resident, due to her sock being "snug." She stated, "Get a different sock, one that is not so tight, so it doesn't rub when we're putting it on." * On 09/24/13 at 3:10 p.m., following cares Resident #7 laid in bed with a blue heel protector on her left foot. At 3:40 p.m., a nurse (#18) entered Resident #7's room and instructed the CNAs (#19 and #20) to remove her heel protector and to replace it with her heel boot when she is in bed. The facility failed to: * Identify Resident #7's left heel deep tissue injury/pressure ulcer prior to it being an "intact, firm, but painful, 2.5 x 4.5 cm purple area," * Keep Resident #7's wound flow sheet in her chart, which did not allow staff to document/monitor any changes, problems, progress towards healing,	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 314	Continued From page 65 * Protect Resident #7 against adverse effects of pressure, friction and shear ("snug/tight" sock and/or pressure of heels resting directly on mattress while in bed,) * Consistently identify and implement the necessary equipment (heel protector versus heel lift boot), and * Identify the specific dietary interventions to be implemented in order to provide sufficient protein to meet Resident #7's healing requirements. - During the initial tour of the facility on 09/23/13 at 12:05 p.m., observation showed Resident #9 in bed and positioned on his back. A nurse (#15) stated the resident's condition has declined in the past few days and staff no longer get him out of bed. When asked about pressure ulcers, the nurse stated the resident had a pressure ulcer to his coccyx on admission (08/30/13) and now it has healed. Review of Resident #9's medical record occurred on all days of survey. Diagnoses included malaise, anorexia, dementia, and a Stage 2 coccyx pressure ulcer. Physician's orders included a Mepilex (a type of wound dressing) to coccyx. The resident's admission MDS, dated 09/05/13, identified severe cognitive impairment, frequently incontinent of urine, required extensive assistance for bed mobility, transfers, toilet use, and personal hygiene, at risk for pressure ulcers, and a current Stage 2 pressure ulcer. Resident #9's current care plan stated: *"Problem . . . Impaired skin integrity: pressure ulcer R/T [related to] incontinence, decreased mobility M/B [manifested by] Stage II H/O [history of] pressure ulcer coccyx, Braden = 14 [moderate risk for developing a pressure ulcer]. . . avoid	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 314	Continued From page 66	F 314		

positioning on the pressure ulcer . . . bed mobility/reposition every 2 hours of [sic] more frequently with assist of 1-2 . . . float heels.
*Problem . . . Potential altered [sic] bladder elimination R/T impaired mobility, unable to access toilet independently M/B frequent incontinence . . . Assist of 2 and mechanical lift to toilet with routine cares and on request . . .
*Problem . . . Impaired mobility . . . Total mechanical lift assist of 2 medium sling; split leg used for toileting . . ."

Resident #9's "Physical Nursing Data" undated assessment identified an open lesion on the resident's coccyx. The assessment provided no description of the lesion. Resident #9's "Wound Flow Sheet," initiated on 08/31/13, identified a 2.0 centimeter (cm) by 2.0 cm Stage II pressure ulcer to the resident's coccyx. Additional assessments, dated September 01-05, 2013 and September 07-11, 2013 showed the nurse(s) failed to document the size of the pressure ulcer.

Observations of Resident #9 showed the following:
*09/23/13 at 4:55 p.m. - Lying in bed with a pillows placed on both his sides next to his torso. His heels rested directly on the bed.
*09/24/13 at 7:55 a.m. - Two CNAs (#16 and #17) checked the resident's brief and placed a pillow under his right buttock and another pillow under his right foot. The resident's right heel rested directly on the pillow and his left foot/ankle rested directly on his right foot.
*09/26/13 at 9:20 a.m. - Two nurses (#14 and #18) positioned Resident #9 on his side and removed his brief saturated with urine and feces. The nurse (#14) removed the dressing on his coccyx and stated the pressure ulcer measured

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 314	Continued From page 67 approximately 0.2 cm by 0.3 cm. Observation showed Resident #9's buttocks reddened. After the nurses completed the dressing and brief change, they positioned him on his left side and placed a pillow between his lower legs. The nurses failed to float the resident's heels. The facility failed to assess and evaluate Resident #9's pressure ulcer at least weekly and failed to float his heels to prevent additional pressure sores.	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of policy and procedures, and staff interview, the facility failed to provide supervision and assistive devices necessary to prevent accidents for 1 of 4 sampled residents (Resident #2) who experienced injuries during falls. Failure to develop goals and a plan of care in order to reduce the risk of accidents, implement measures consistent with Resident #2's needs, and evaluate those measures, to prevent falls, all which occurred from a wheelchair, resulted in multiple incidents of injury to Resident #2 and one visit to the emergency room due to	F 323	F 323 1. Resident #2's individual needs have been met by reviewing her fall data collection tool and updating her care plan for current fall interventions. Current interventions in use at this time including a larger sensory matt for her bed and w/c that plays music instead of the beep alarm to reduce agitation from the alarm, a new electric bed on 11-05-2013. This new bed frames goes very low to the ground and has a concave mattress and a second matt is placed on the floor next to the bed so she doesn't hurt herself when she rolls out of bed. The resident doesn't use the broda chair any longer but staff continues to bring her out to the nursing station during the night and place her in a recliner when she is restless. Staff will continue to offer interventions of offering food and drink, 1:1 visit when she is restless during the night, prefers	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 68 unresponsiveness following a fall. Findings include: Review of the facility guidelines for "Prevention and Management of Falls" occurred on September 26, 2013. The policy, dated 04/2011, stated, ". . . In order for a Falls Prevention program to be successful . . . . . . each resident will be evaluated to determine his or her risk for falling. Include the following components for review: . . . Identification of environmental hazards and any individual resident risk of an accident, including the need for supervision Evaluation and analysis of the hazards and risks related to potential falls Implementation of interventions, including adequate supervision, consistent with resident needs, goals, plan of care and current standards of care and current standards of practice in order to reduce the risk of an accident. Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current standards of practice. PREVENTION STRATEGIES Environmental . . . Any hazards discovered should be removed or corrected immediately. Modification of the resident's environment should accommodate his/her individual needs. . . . Medical Management Involvement of the resident's health practitioner is vital. The physician can provide evaluation of medical interventions for any acute and chronic conditions and assess the impact to a resident's fall risk due to the presence of these conditions. . . .	F 323	to have a room mate and be around other people. The LPTA adjusted her wheelchair seat to prevent her from leaning or falling forward out of her wheelchair. She has not fallen from the wheel chair since this modification on 10-21-2013. 2. All residents have the potential to fall. A list of resident that have fallen in the past 6 months will be generate and each resident will be reviewed to ensure they have a currently fall risk care plan and appropriate interventions to prevent future falls. 3. A nursing inservice will be held on 11-12-2013 to educate the staff on the facility guidelines for Prevention and Management of Falls. Education on the need to identify resident as a falls risk, if the falls data collection is completed timely, determined causative factors, and provided interventions to prevention the repeat of falls or fall with major injury. Reevaluation on intervention and care plan will occur with the investigation of the incident. 4. An audit tool will be developed to determine if the falls data collection tool is completed within 24 hours admission. If the temporary care plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 69 Medications Drug regimen reviews . . . should be reviewed for recommendations with specific attention focused on those medications that may increase the fall risk or may have contributed to actual fall. Nursing staff should evaluate the effectiveness, presence of side effects, adverse consequences and the necessity of continued medication usage as part of regular clinical monitoring. Ambulation/Functional Deficits Ongoing evaluation of a resident's level of function is required. . . . decline in physical function may be at increased risk of fall. . . . Activities A program of activities which is geared to meeting the needs of all residents can be used as an intervention to prevent falls. . . . Tracking/Trending A tracking mechanism should be utilized to assist in the evaluation of resident specific information . . . Falls Committee The Interdisciplinary Team should perform an analysis of the precipitating events for individual resident falls and evaluate potential interventions aimed at prevention of future falls. . . . [and] perform ongoing systematic evaluation to determine the effectiveness of the Falls Prevention Program. Quality Improvement . . . should . . . look for trends in Falls location, time and date, risk factor management and potential root cause. . . . to develop an effective action plan or idea . . ." On the morning of 09/23/13, a supervisory nursing staff member (#1) stated Resident #2 doesn't sleep in her bed, but rather sleeps in a Broda chair (a tilt and recline positioning	F 323	addresses the fall risk and appropriate interventions have been put into place to prevent a fall. An incident report will be completed at the time of the fall and new interventions will be added timely to prevent the reoccurrence of the falls. All new fall interventions will be re-evaluated in four days to determine if the intervention is effective. The audit will be completed by the DNS or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the QA committee for further recommendations. 5. 11-29-2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 70 wheelchair/chair) with a chair alarm. Review of Resident #2's medical record occurred on all days of survey. Resident #2's medical diagnoses included senile dementia, mood disorder, anxiety, agitation, and degenerative disc disease. A comprehensive assessment, dated 03/02/13, included the following trigger: * Falls: "Resident has had a fall incident which places her at risk for falls. She also has mobility deficits and is transferred per mechanical lift or sit to stand lift depending upon her compliance status. . . . She used the wheelchair for mobility. . . . had a fall incident which she fell asleep in the wheelchair and slipped out of it. She did substain [sic] a bruise on her forehead from fall. She has safety awareness deficits due to her dementia. . . . She does at times wander about in her wheelchair but is generally situated at nurse's station for close supervision. . . . Proceed to care plan? Yes, Why or why not? To prevent fall and fall related injuries. . . ." Resident #2's current care plan identified the problem of "Impaired mobility and potential for falls r/t dementia, arthritis . . . m/b [manifested by] non-ambulation" with approaches of "Will not sleep in bed. Place in Broda chair or recliner at bedtime. . . . Sit/stand lift and assist of 2 when cooperative; Total mechanical lift and assist of 2 when uncooperative/sleepy . . . Sensor mat to bed and chair. . . ." An interdisciplinary assessment, dated 05/28/12, identified the use of a Broda tilt-n-space chair, and showed the chair in use beginning on 05/22/12. The purpose of the chair being "helps her get restful sleep." An assessment on 08/09/12 identified the Broda	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 71	F 323		

chair being "helps her get restful sleep." An assessment on 08/09/12 identified the Broda tilt-n-space recommended by the physical therapy assistant. A "fall data collection tool," dated 02/20/13, identified the resident at risk for falls, with a fall risk score of 22 (a score of 12 or more indicates high risk).

Resident #2's record identified the following falls:
* 09/25/12 at 4:15 p.m.: "Slid herself out of w/c [wheelchair] to the floor. No injuries noted." The incident details identified a chair alarm that did not sound because "it slid [with] her and she leaned against it with her back." A comment included "May need to add tab alarm." Observation on all days of survey did not show the presence of a tab alarm.
* 10/05/12 at 3:50 p.m., "scooted out of w/c . . . No injury"
*10/20/12 between 2:00 p.m. and 4:45 p.m., nursing staff administered "Medication" for restlessness and trying to get out of her chair. At 4:35 p.m., "Resident was found on the floor face down." The incident report identified nursing staff administered Ativan one mg within the four hours prior to the fall. With the fall, nursing staff identified a bruise and contusion on the resident's forehead and began neurological checks, and "Resident became lethargic and fell asleep in wheelchair. Tried to wake resident but she would not wake. Ambulance were called." The resident returned to the facility at 8:50 p.m. and the assessment showed resident with a 2 x 2 cm (centimeter) light purple raised bruise on [left] forehead, 6 x 5 cm non-raised bruise for [sic] [right] forehead from outer [right] eye to scalp-line. . . ."
* 11/18/12 at 4:40 a.m., "Staff heard sound et looked to find resident lying face down on floor in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 72	F 323		

front of wheelchair. [Left] side of face against floor." The report identified the fall occurred in the hallway by the nurse's station and staff noted a "lump on (L) outer edge of eye" and neurological checks initiated. An interdisciplinary progress note (IDPN), dated 11/19/12 at 8:00 a.m. stated ". . . Lt [left] eye lid brow et [lower] eye bruising. . . ."
* 02/20/13 at 7:30 a.m., fall in hallway by nurse's station, "Sleeping in w/c in hallway - fell forward out of w/c." The report identified the resident sustained a laceration/abrasion and administered an "ice pack to head."
* 08/02/13 at 7:00 a.m., a fall in the hallway by the nurse's station, "Res [resident] fell asleep in wheelchair, leaning too far to one side & tipped over. [no] apparent injury, denies pain/injury. Neurochecks started." The report identified the resident fell onto her right side, and her "forehead slightly red."
* 08/29/13 at 11:50 p.m., "Res was in w/c in commons area by desk. Staff heard chair alarm and res was tipped over in w/c laying on left side. Has pad alarm so did not alarm until w/c was tipped over."

The record identified falls occurred on at least two occasions when the chair alarm did not sound.

An entry in an IDPN, dated 08/03/13, stated ". . . Sensor mat to chair as resident will physically scoot herself fwd [forward] in chair & has had multiple falls. Note that @ times resident has poor posture in her w/c. Will lean trunk to the [left]. Curvature of spine affects positioning of trunk as well as fatigue in her core musculature. Staff encouraged to reposition as often as needed [with assist of two]. . . ."

During interview on 09/25/13 at 9:10 a.m., a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 73 list" which identifies "briefly" what the expectation is for CNAs regarding cares. The list identified Resident #2 as a "fall risk." The nurse stated the interventions included a bed/chair sensor and stated that also includes taking the resident to activities and do activities with her. The list did not identify preferred/effective activities for staff to utilize. During interview on the morning of 09/26/13, an administrative nurse (#3) stated she has not done any tracking or trending of Resident #2's falls. The nurse referred the question to another staff member, specifically staff member #4. A staff member (#4) referred the surveyor to the physical therapy department regarding Resident #2 leaning to her left side while her eyes were closed (asleep) in the wheelchair. The facility failed to prevent Resident #2's falls by not assessing, including determining causative factors, implementing measures, and evaluating those measures for effectiveness. This resulted in Resident #2 sustaining falls from a wheelchair which resulted in injuries to the resident's head and a visit to the emergency room due to unresponsiveness following a fall. Observation also showed nursing staff (CNAs) transferred Resident #2 with a sit-n-stand lift verses a total mechanical lift during sleepy periods, placing the resident at risk for additional falls.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 332	Continued From page 74 This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to ensure a medication error rate of less than five percent during observation of medication administration for 2 of 2 supplemental residents (Resident #17 and #18) who received insulin. Failure to provide a meal within a timely manner after staff administered NovoLog insulin has the potential for a hypoglycemic (low blood sugar) episode. Three errors occurred during staff administration of 33 medications, which resulted in a 9 percent error rate. Findings include: Review of the manufacturer's instructions for NovoLog insulin occurred on 09/24/13. The instructions stated, ". . . You should eat a meal within 5 to 10 minutes after using NovoLog to avoid low blood sugar. NovoLog is a fast-acting insulin. The effects of NovoLog start working 10 to 20 minutes after injection. . . Do not inject NovoLog if you do not plan to eat right after your injection. . . ." - Observation of medication pass on 09/23/13 at 5:10 p.m., showed a nurse (#14) administered 5 units scheduled NovoLog and 8 units of sliding scale NovoLog to Resident #17. The medication administration record stated the insulin should be given with meals. Observation until 6:00 p.m. revealed no one offered this resident any food or juice before the meal service started at 6:00 p.m. - Observation of medication pass on 09/23/13 at 5:40 p.m., showed a nurse (#13) administered 18	F 332	F 332 1. Resident # 17's individual needs have been met by receiving her insulin according to the MD's order of Novolog insulin four times per day and a sliding scale of three times per day. The physician orders and care plan have been updated to offer food or juice with short acting insulin or the resident needs to eat within 5-10 minutes from the administration on the insulin. ~~Care plans~~ Resident # 18's individual needs have been met by receiving her insulin according to the MD's order of Novolog insulin three times per day. The physician orders and care plan have been updated to offer food or juice with short acting insulin or the resident needs to eat within 5-10 minutes. 2 A list of residents that are receiving short acting insulin has been generated. These residents physician orders and care plan have been updated to offer food or juice with short acting insulin or the resident needs to eat within 5-10 minutes of administration of the insulin.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 332	Continued From page 75 units of scheduled NovoLog to Resident #18. Observation until 6:00 p.m. revealed no one offered this resident any food or juice before the meal service started at 6:00 p.m. During an interview on 09/24/13 at 5:15 p.m., a nurse manager (#2) stated the nurse administering the insulin used her judgement depending on the resident's blood sugar level on how soon before meals to give the NovoLog insulin. The nurse stated there were no facility guidelines to follow. During an interview on 09/26/13 at 11:05 a.m., an administrative nurse (#3) stated the facility had no guidelines for the administration and timing of NovoLog insulin. She agreed nurses should follow the manufacturer's recommendations for administration to avoid hypoglycemia.	F 332	3. A nursing inservice will be held on 11-12-2013 to educate the nurses on the Drug Reference Handbook on novolog insulin administration. The DNS worked with a diabetic educator to provide an inservice on the different types of insulin and the need to provided food or juice with the administration of a short acting insulin such as Novolog or the resident needs to eat within 5-10 minutes of the administration of the insulin.	
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of policies/procedures, review of professional reference, and staff interview, the facility failed to ensure 1 of 13 sampled residents (Resident #5) received the correct dose of medication per physician's order. Failure to receive the correct medication dose resulted in Resident #5 hospitalized for symptoms of withdrawal. Findings include:	F 333	4. An audit tool was developed to monitor the administrator of short acting insulin and if the resident was offer food or juice or if the resident ate within 5-10 minutes to avoid a hypoglycemic reaction. The audit will be completed by the DNS or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the QA committee for further recommendations. 5.11-29-2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 333	Continued From page 76 "Nursing 2013 Drug Handbook," 33rd edition, Lippincott, Williams & Wilkins, Philadelphia, pages 576-580, identified, "Fentanyl . . . CONTRAINDICATIONS & CAUTIONS . . . Use with caution in elderly or debilitated patients. . . . Advise patient not to stop drug abruptly. . . ." Resident #5's medical record, reviewed September 23-26, 2013, identified diagnoses including Alzheimer's dementia, anxiety, hemangioma [noncancerous tumor] to the liver with severe kyphosis [abnormal curvature of the upper spine], history of thoracic and lumbar fractures, recent hip fracture, and abdominal, back, and hip pain. The resident's quarterly Minimum Data Set (MDS), dated 07/27/13, identified problems with memory, moderately impaired daily decision making skills, extensive assistance for activities of daily living (ADLs), and use of scheduled and as needed pain medications. The current care plan identified, "Problem: Altered comfort . . . Approaches: Medicate as ordered. Monitor for adverse consequences . . ." The physician's orders identified the following: * 09/22/09, Oxycodone 15 mg [milligrams] every two hours as needed for pain * 01/16/10, Oxycodone 40 mg twice daily for pain * 01/19/10, Fentanyl Patch 150 micrograms (mcg)/hour for pain The physician's order and medication administration record (MAR) both stated, ". . . Change [Fentanyl Patch] q [every] 72 hr [hours]. Disposal of old patch as follows: Two nurses witness patch wrapped in toilet tissue and flushed down toilet. Both nurses sign off disposal. . . ."	F 333	F 333 1. Resident #5 expired on 10-22-2013. 2. All residents that are receiving topical Fentanyl patch have the potential to be affected in this area. The list of residents will be generated and have their pain patch checked every shift and during the initial application the staff is to write the location of the patch, and upon removal of the patch two nurses to witness the removal of the patch, wrap it in tissue and flush it down the toilet. Both nurses initial on the EMAR the destruction of the patch. 3 .A nursing inservice will be held on 11-12-2013 to educate the staff on Drug Handbook for Fentanyl and the procedure for counting and reconciliation of controlled substances. During this inservice staff will be educated on the clear patch cover that is available to be placed over the top of the patch so it doesn't fall off as easily during bathing and routine cares. The staff will also be educated on the procedure titled, Controlled Substances" to verify counts and document on the GSS 247 Controlled drug count record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 333	Continued From page 77 Resident #5's progress notes identified the following: * 01/01/13 at 8:30 a.m., "Resident in dining room for breakfast when CNAs [certified nurse assistants] called nurse to table. Resident had 'shakes,' involuntary movement noted. She did not want anyone to touch her during her 'spell.' Began to remove clothing and became very agitated. . . . Resident taken to her room where involuntary movements almost like a seizure-type continued and worsened - unable to obtain blood pressure due to shaking resident crying and wants to go to 'doctor' . . ." * 01/01/13 at 8:40 a.m., "Unit supervisor notified and CNA stays [with] resident in room meds [medications] not given orally due to shaking as I worried that she could not swallow them properly . . ." * 01/01/13 at 9:00 a.m., "Notified [Hospital] ER [emergency room] that resident was going to be sent to ER for above symptoms . . ." * 01/01/13 at 11:15 a.m., "Phone call from [Physician] . . . admit to [Hospital] . . ." The [Hospital] Discharge Summary, dated 01/03/13, identified, ". . . HOSPITAL COURSE: [Resident #5] . . . admitted into observation on 01/01/13 after presenting to the ER with altered mental status. Specifically increased agitation compared to baseline. Patient was having trouble sitting still. She would not let anyone touch her to do any kind of assessment. She is complaining of arm and legs and everything hurting. She would also have jerking movements in her arms. . . . It seemed like she would not be able to stop her arms and she would have the jerking for a few seconds and then it would pass for a while. In patient's initial assessment it was noted that she was missing one of her fentanyl patches. Patient	F 333	System change: GSS 247 A titled, "Controlled drug-count record" will be used every 12 hour shift to ensure the count of all narcotics is accurate at the time of shift change. Each of the off going and on coming nurses will sign that the narcotic count is correct. 4. An audit tool will be developed to monitor the reconciliation of controlled drugs and verify the documentation of two nurses every shift (12 hours) to document that count of all narcotic accurate on the GSS 247. The audit will be completed by the DNS or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the QA committee for further recommendations. 5. 11-29-2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 333	Continued From page 78	F 333		

is on a total dose of 150 micrograms per hour which she receives through one 100 microgram patch in combination with one 50 microgram patch. It was found that she had only her 50 microgram patch on. On the day prior patient had also had nausea and diarrhea. All of the symptoms were suspected to be from narcotic withdrawal. Patient was given initially IM [intramuscular] and later IV [intravenous] fentanyl which did calm her down and relieve symptoms. . . . FINAL DIAGNOSES: 1. Narcotic withdrawal, resolved. . . ." The Physician's Progress Note, dated 01/02/13, identified, ". . . 2. Increased agitation, restlessness, and arm tremor/jerking likely secondary to above."

The physician's discharge orders identified the following:
* 01/01/13, Oxycodone 40 mg twice daily for pain
* 01/01/13, Fentanyl Patch 100 mcg every 72 hours for pain
* 01/01/13, Fentanyl Patch 50 mcg every 72 hours for pain

The January 2013 MAR, also identified:
* " . . . [Handwritten notation] Write site of patch placement: RC [right chest], LC [left chest], RB [right back], LB [left back]."
The record failed to identify the site of placement on 01/19/13 and 01/25/13.
* " . . . [Handwritten notation] 01/03/13 [start date] Check for placement of Fentanyl patch every shift."

The progress notes identified the following:
* 01/30/13 at 8:50 a.m., "Resident noted to be missing Fentanyl Patch 50 mcg [micrograms] - none found in room - had been applied to Rt [right] upper anterior chest on 01/28/13 . . ."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 333	Continued From page 79 * 01/30/13 at 1:00 p.m., "[Nurse Practitioner] notified - [Registered Nurse] also checked resident's skin with me and no patch found . . . " * 01/30/13 at 2:30 p.m., "Orders received from [Nurse Practitioner] and new patches will be applied today and will follow schedule of [sic] before of two days on and change the 3rd day." The February 2013 MAR, identified, ". . . Change q 72 hr. Write site of new patch placement (right chest, left chest, right back, left back). . . . 12/01/12 Check for placement of Fentanyl patch every shift." The record failed to show the site of placement on 02/08/13. During an interview on 09/25/13 at 8:50 a.m., a managerial nurse (#12) stated, "We started checking for the placement of the patches last year sometime." A progress note, dated 02/18/13 at 9:40 p.m., identified, "Sitting [up] on edge of bed - Tremors of UE's [upper extremities] - c/o [complains of] 'muscle spasms' - severey [sic] anxiety - Rx [Medicated] [with] oxycodone 15 mg [milligrams] po [orally] per prn [as needed] order - unable to [check] vs [vital signs] [secondary to] anxiousness/shaking. - Transferred [sic] to w/c [wheel chair] [and] taken to nurses station to monitor. - Fluids given - unable to calm . . . Also noticed Fentanyl patch (applied 02/17) not on - new Fent [Fentanyl] patches (100 mcg [and] 50 mcg) applied [and] covered [with] OpSite to Rt/Lt [left] mid back." Resident #5's narcotic record, dated December 13, 2012-February 22, 2013, also identified the facility failed to verify the correct count of her	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 333	Continued From page 80 Fentanyl medication on the following days: * December: 14, 17, 20, 21, 22, 23, 25, 26, 28, and 31 * January: 3, 4, 6, 8, 10, 11, 13, 15, 16, 17, 21, 22, 23, 26, 27, 28, and 29 * February: 1, 5, 6, 7, 8, 9, 11, 14, 15, 19, 20 and 21 During an interview on 09/25/13 at 1:30 p.m., an administrative nurse (#3) and a managerial nurse (#15) reported they were unable to locate any investigative reports concerning the three episodes involving the missing Fentanyl patches. They further reported, "We checked the bedding and the laundry." The facility failed to implement effective interventions following the disappearance of Resident #5's pain medication which resulted in the resident experiencing discomfort and being hospitalized on one occasion for symptoms of withdrawal. They also failed to 1) thoroughly investigate the three episodes (01/01/13, 01/30/13, and 02/18/13) involving Resident #5's missing Fentanyl patches, 2) identify the site of placement on three occasions between January 19, 1013-February 8, 2013, and 3) reconcile the medication on twenty-two occasions between December 12, 2013-February 22, 2013.	F 333		
F 368 SS=B	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a	F 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 368	Continued From page 81 substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on review of facility policies/procedures, resident group interview, and staff interview, the facility failed to ensure bedtime snacks were offered to all residents in 2 of 2 wings (East/West and North). Failure to offer bedtime snacks to all residents could result in residents experiencing weight loss. Findings include: Review of the facility policy titled "Frequency of Meals and Snacks" occurred on 09/24/13. This policy, dated August 2012, stated, ". . . 12. Snacks are to be offered to all residents each night. . . ." During the resident group interview, on 09/24/13 at 10:00 a.m., Resident A, B, C, D, E, and F stated staff did not offer bedtime snacks. Resident D stated residents had to ask the staff for snacks at bedtime if the resident wanted one. During an interview, on 09/24/13 at 2:35 p.m., two nursing staff members (#10 and #11) stated staff	F 368	F 368 1. No specific resident was cited in this survey. An HS snack cart has been made available starting 9-24-2013 to offer all residents a snack in the evening. On 10-14-2013 staff met on the HS snacks process. After recommendations from nursing staff and dietary staff the snack cart was eliminated and stocking of nutrition center by dietary daily was more efficient. 2. All residents have the potential to be affected in this area. An HS snack will be offered to all residents starting 9-24-2013. The kitchen will stock the nutrition center at each nurses station with a assorted snack items for regular and diabetic diets. 3. All staff education on 11-14-2013 will be held to educated staff on the Procedure of meal service/dining frequency of meals and snacks and the importance of offering and documenting that all residents have been offered a snack at bed time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 368	Continued From page 82 used the snack cart to pass afternoon snacks. Certified nursing assistants (CNAs) then passed bedtime snacks that were labeled with a resident's name but did not offer each resident a bedtime snack. The CNAs would get a snack for any resident that specifically asked for one. During interview on 09/24/13 at 3:30 p.m., an administrative dietary staff member (#9) stated dietary staff left snacks at both the wings' kitchenettes for the CNAs to pass before bedtime. She stated the CNAs record intake for those residents who had labeled snacks due to special dietary needs, but did not record if all other residents were offered and then accepted or refused a snack. The CNA documentation showed no bedtime snack intake percentage recorded for Resident A, B, C, E, and F for September 2013.	F 368	3. System change: A documentation record with all residents was developed and placed at each nurses station. Staff will educate that they need to offer and document if the residents received HS snacks on this record. The snack pass record form will be turned in to the licensed nurse for an additional review before the CNA's will be allowed to leave the facility. After the review ensuring all residents have been offered an HS snack the nurse will place the snack pass documentation tool in the dietary managers mail box. The dietary manager will collect and review the documentation records weekly.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	3. System change: The dietary manager will posted a sign stating, "Foods available 24 hours per day" and list the items residents can have 24 hours a day. The dietary manager will take the sign to the next resident counsil meeting and inform the residents of the food items available 24 hours per day and to ask the residents where the best place would be hand the posting. In the mean time the Foods always available will be posted in the main dining and at each nurses station.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 431	Continued From page 83 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy and procedure, and staff interview, the facility failed to ensure Fentanyl, a Schedule II controlled substance, was reconciled at the change of shift for 1 of 1 sampled resident (Resident #5), and Clonazepam, a Schedule IV controlled substance, was reconciled at the change of shift for 1 of 1 sampled resident (Resident #7). Not periodically verifying the correct count of the controlled substances has the potential for medication errors and/or drug diversion. Findings include: The facility policy titled "Controlled Substances," revised August 2013, stated, "Policy: . . . To provide verification and correct count of controlled substances on hand, To provide safe storage for controlled substances . . . Note: At change of	F 431	4. Two audit tools will be developed to ensure all residents are offered a bed time snack. The first audit will be completed to monitor the documentation process of the HS snacks three times per week for 4 weeks, then weekly for four weeks, then monthly for one month. The second audit will be the dietary manager asks 3 residents per wing three times per week for 4 weeks if they were offered an HS snack, then she will ask 3 residents per wing weekly for four weeks, then monthly for two month. The dietary manager or designee is responsible for the completion of the audits. The audit results will be reported to the QA committee for further recommendations. 11-29-2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 431	Continued From page 84 shift, on-duty and oncoming nurses count [controlled substances] . . . Procedure: 1. One nurse unlocks the controlled substances storage unit and counts controlled drugs . . . on hand for each resident, 2. The other nurse assists by watching and verifying the count in the individual resident's Medication Administration Record . . . 3. If the record and actual count are in agreement, both nurses need to initial the Medication Administration Record . . ." During an interview on 09/24/13 at 5:00 p.m., with a nurse supervisor (#2) and on 09/25/13 at 3:30 p.m., with an administrative nurse manager (#3) both stated that nurses do the narcotic count on a daily basis and not at each shift change. - Resident #5's medical record, reviewed September 23-26, 2013, identified diagnoses including history of thoracic and lumbar fractures, recent hip fracture, and abdominal, back, and hip pain. The resident's quarterly Minimum Data Set (MDS), dated 07/27/13, identified the use of scheduled and as needed pain medications. The physician's order, dated 01/19/10, identified, "Fentanyl Patch 150 micrograms (mcg)/hour for pain. . . . Change [Fentanyl Patch] q [every] 72 hr [hours]." Resident #5's narcotic record, dated December 13, 2012-February 22, 2013, identified the following: The facility failed to reconcile her Fentanyl medication on the following days: * December: 14, 17, 20, 21, 22, 23, 25, 26, 28, and 31 * January: 3, 4, 6, 8, 10, 11, 13, 15, 16, 17, 21, 22, 23, 26, 27, 28, and 29	F 431	F 431 See F 333 for POC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 431	Continued From page 85 * February: 1, 5, 6, 7, 8, 9, 11, 14, 15, 19, 20 and 21 The facility failed to reconcile Resident #5's Fentanyl medication on 39 of the 72 days. The facility reconciled her Fentanyl medication once a day on the remaining 33 days. - Resident #7's medical record, reviewed September 23-26, 2013, identified diagnoses including dementia and anxiety. The physician's order, dated 01/19/10, identified, "Clonazepam 0.5 mg [milligram] BID [twice daily] prn [as needed]." Resident #7's narcotic record, dated August 29, 2013-September 25, 2013, identified the following: The facility failed to reconcile her Clonazepam medication on the following days: * August: 30 * September: 2, 4, 5, 7, 8, 11, 14, 16, 19, 21, 23 The facility failed to reconcile Resident #7's Clonazepam medication on 12 of the 28 days. The facility reconciled her Clonazepam medication once a day on the remaining 16 days.	F 431		
F 494 SS=D	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program	F 494	F 494 1. Employee A's certification expired on 7-27-2013 not 1-31-2013 as listed in the 2567. The employee was taken off the schedule until her certification was active on the state of ND CNA registry on ~~7-27-2013.~~ 8-15-13 Phone call to DON on 11-21-13 KB	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 494	Continued From page 86 approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter. This REQUIREMENT is not met as evidenced by: Based on review of the state nurse aide registry files, facility record review, and staff interview, the facility failed to ensure 1 of 4 nursing assistants (Individual A) working with residents in the facility remained certified. Individual A provided 84.75 hours of nursing related services without the facility verifying competency through certification. Failure to ensure certification of caregivers has the potential to affect resident care. Findings include: Review of employee files on 09/25/13 at 1:30 p.m. with an administrative staff member (#8) revealed Individual A's certification expired on ~~01/31/13.~~ This nursing assistant worked with residents in the facility without certification for a total of 84.75 hours between 07/27/13 and	F 494	2. All residents have the potential to be effected in this area. A list of CNA's and their certification expiration date has been generated and checked for expiration dates through January of 2014. All of the facilities CNA's have current certifications at this time and one CNA's certification will expired before Jan. 2014 and this employee has been notified. 3. System change: The secretary will generate and print a copy of the certified nursing assistants' certification expiration dates and give a copy to the DNS. The DNS will check the list for any CNA's certification that will expire in the next two months. The DNS will inform each CNA 2 months in advance of their expiration date of certification to ensure compliance in this area.	

7-27-13 per phone Call with DON on 11/21/13 LB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 494	Continued From page 87 08/15/13. During an interview on the afternoon of ~~07/19/13~~, an administrative staff member (#3) verified Individual A's certification expired and the facility's process failed to identify the expired certification. 9/25/13 Per phone call to DON on 11/21/13 KB	F 494	The secretary and CNA's will be in serviced on 11-12- 2013 on the ND CNA certification renewal process and requirements for renewal. 4. An audit will be developed to monitor CNA expirations dates. The audit will be completed by the DNS or designee monthly for three months, then quarterly for three months. The results of the audit will be reported to the QA committee for further recommendations. 5. 11-29-2013	