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 _____	06/22/2017

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 06/19/17 and completed on 06/22/17, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The	F 280		7/27/17

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

Electronically Signed | 06/29/2017

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 _____	06/22/2017

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 1 planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	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 _____	06/22/2017

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 2 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 3 of 13 sampled residents (Resident #1, #8, and #9). Failure to revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plan" occurred on 06/22/17. This policy, revised 11/2016, stated, ". . . Each resident will have an individualized, person-centered, comprehensive plan of care . . . This plan of care will be modified to reflect the care currently required/provided for the resident." Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, ". . . Toilet Use: Resident will use gait belt and walker and 2 staff . . ." Observations on 06/21/17 at 7:45 a.m. and 10:40 a.m. showed one staff member assisted Resident	F 280	1. Resident #1□s care plan has been updated to reflect that she is toileted with assist of one staff, gait belt with walker. Resident #8□s care plan has been updated to reflect that the air mattress has been removed from her bed and the float left heel has been removed from the care plan. Resident #9□s care plan has been updated and no longer reads that he has a Jobst stocking to right leg or that he has a personal alarm in place. Dietary portion of care plan also updated, resident no longer prefers to eat in his room. 2. All current residents have the potential to have a care plan not updated. 3. The MDS nurse will update care plans quarterly during the MDS assessment. The Unit Managers will update care plans daily as needed when orders are received. Education will be provided to dietary and nursing staff at the mandatory nurse/CNA meeting on July 11, 2017 or July 13, 2017 or prior to their next scheduled shift. We will be reviewing Policy and Procedure titled, 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 _____	06/22/2017

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 3 #1 with toileting. During an interview on 06/21/17 an administrative nurse (#2) stated Resident #1 only required one staff member for toileting and the care plan failed to reflect this change. - Review of Resident #8's medical record occurred on all days of survey. The current care plan stated, "The resident has potential for pressure ulcer development . . . Ensure left foot is floating on pillow . . . Provide pressure relieving air mattress . . ." Throughout the survey, observation showed Resident #8 had a left above-the-knee amputation and no air mattress on the bed. During an interview on 06/21/17 at 5:45 p.m., an administrative nurse (#2) confirmed the care plan should refer to Resident #8's right versus left foot. The nurse stated staff had removed the air mattress from Resident #8's bed as she preferred to sleep in the recliner. The nurse stated staff now apply a foam dressing to her right ankle as she is sleeping in the bed again and is noncompliant with floating her foot. - Review of Resident #9's medical record occurred on all days of survey. The current care plan stated, "The resident has impaired circulation R/T [related to] lymphedema . . . Currently wearing compression stocking on right leg only until sore to inner left ankle heals. . . ," "The resident has had an actual fall . . . Personal Alarm: (Specify type of alarm) used to alert staff to resident's movement . . . ," "The resident has nutritional problem . . . Resident to eat in room	F 280	4. An audit tool will be developed to monitor care plans being updated appropriately. Audit will completed by DNS or Designee as scheduled: 2 care plans weekly X 4 weeks, then 5 care plans monthly X 5 months, then 4 care plans quarterly X 2 months. Findings will be reported to QAPI committee for further recommendations.	

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 _____	06/22/2017

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 4 during meals per his preference. . . ." The record showed the sore on Resident #9's left ankle healed by 01/03/17, and the resident fractured his right ankle on 06/08/17 with subsequent external fixation repair. Throughout the survey, observation showed Resident #9 wore a compression stocking to his left leg only, had an external fixator to his right lower leg, had no personal alarm, and ate meals in the dining room. During an interview on 06/21/17 at 8:35 a.m., a certified nurse aide (CNA) (#4) confirmed Resident #9 did not use a bed or chair alarm. During an interview on 06/21/17 at 5:45 p.m., an administrative nurse (#2) verified Resident #9's care plan was incorrect regarding the compression stockings and eating in his room.	F 280		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment	F 441		7/27/17

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 _____	06/22/2017

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 441	Continued From page 5 implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 441		

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 _____	06/22/2017

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 441	Continued From page 6 (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 1 of 2 residents (Resident #17) observed during blood glucose monitoring. Failure to follow infection control practices related to disposal of lancets into a sharps container during glucose monitoring has the potential to spread infection to residents, staff, and visitors. Findings include: Review of the facility policy titled "Blood glucose monitoring, disinfecting, and cleaning" occurred on 06/22/17. This policy, revised May 2016, stated, ". . . collecting a fingertip sample, position the lancet . . . prepare a drop of blood and test according to specific equipment manufacturer's instructions. Discard the test strip and dispose of lancet in sharps container. . . ." Observation on 06/20/17 at 10:20 a.m. showed a licensed nurse (#1) assisted Resident #17 with blood glucose monitoring. The nurse (#1) used a lancet to obtain blood from Resident #17's finger.	F 441	1. Resident□s #17□s individual needs have been met by nursing staff disposing of the lancet in a sharps container. 2. All current residents that have accuchecks performed have the potential to be affected by this deficiency. 3. Education was communicated to all staff via Point Click Care □ Communication Board regarding deficiency on June 20, 2017. Copy of Policy and Procedure has been placed at each nurse□s station for nursing staff to review and acknowledge. All nursing staff will be educated on July 11, 2017 or July 13, 2017 at a mandatory nurse/CNA meeting or prior to their next scheduled shift. We will be reviewing Policy and Procedure titled, Injections and Medical Waste Program Guidelines. 4. An audit tool will be developed to observe if nurse is disposing of the lancet in the sharps container after each use. If not, was education provided to nurse at the time of observation? Audit will be completed by Infection Preventionist 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 _____	06/22/2017

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 441	Continued From page 7 The nurse (#1) disposed of the contaminated lancet into a trash can. During an interview on 06/21/17 at 5:50 p.m., an administrative nurse (#2) and an administrative staff member (#3) confirmed used lancets should be placed into a sharps container.	F 441	Designee 3 □ 5 times weekly X 2 weeks, then weekly X 4 weeks, then monthly X 2 months, then quarterly X 3 quarters. Findings will be reported to QAPI committee for further recommendations.	