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 _____	09/24/2015

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 MDS 3.0/Staffing Focused Survey started on 09/22/15 and completed on 09/24/15, the sample included 10 residents for focused review.	F 000		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced	F 278		10/18/15

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

Electronically Signed | 10/16/2015

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 _____	09/24/2015

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 278	Continued From page 1 by: Based on record review, review of the RAI (Resident Assessment Instrument) User's Manual, review of facility policy, and staff interview, the facility failed to complete Minimum Data Sets (MDSs) which accurately reflected the residents' status for 7 of 10 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7). Failure to accurately code behaviors, active diagnoses (pressure ulcers and urinary tract infections), nutrition or hydration interventions, bladder appliances, and medications does not allow the resident assessment to reflect their current status/needs and may result in inaccuracy of the facility's Resident Level Quality Measure Reports. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2014, pages 1-8, stated, ". . . While CMS [Centers for Medicare and Medicaid Services] does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. . . ."	F 278	1. Resident's # 1, #2, #3, #4, #5, #6, and #7 have all had their MDS's reviewed, revised and corrected as indicated by the MDS team on 10/18/15. All care plans were reviewed and revised as indicated by the unit supervisors on 10/18/15. Behaviors Resident # 5 has been assessed and received documentation summary related to behaviors by the LSW on 10/18/15. The care plan has been reviewed and revised as indicated. The error in counting CNA documentation has been corrected and the canned template appearance will not reoccur. Active Diagnosis Resident #5 has had care plan reviewed and revised as indicated to reflect only active diagnosis of pressure ulcers as indicated. Urinary Tract infection Diagnosis Resident # 6's MDS was corrected on 10/18/15 by MDS team. Nutrition or Hydration Interventions Resident #1, #3, #5, and #4 have received full assessments by the Dietary manager and Registered Dietician on 10/18/15. Resident #2 is no longer in the facility Bladder appliances Resident #2 is no longer in the facility	

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 _____	09/24/2015

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 278	Continued From page 2 BEHAVIORS The Long-Term Care Facility RAI User's Manual, revised October 2014, Chapter 3 pages E-4, E-5, and E-13 stated, ". . . E0200: Behavioral Symptom - Presence and Frequency. A. Physical behavioral symptoms directed toward others (e.g. hitting, kicking, pushing, scratching, grabbing, abusing others sexually). B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). C. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) . . . E0800: Rejection of Care - Presence and Frequency. Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals . . . Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems - and may therefore require treatment planning and intervention - from those	F 278	Medication received Resident #7's MDS was corrected on 10/18/15 by the MDS team. 2. A facility wide audit was completed by the MDS team/Dietary/Registered Dietician, Infection Preventionist, HIM and LSW, looking back 90 days to review sections: E0200, E800, I8000, I2300, M1200, H0100, and section N of the MDS. All residents that had potential to be affected by the same practices related to : Behaviors, rejection of cares, active diagnoses, Urinary tract diagnosis, Nutrition or Hydration intervention, bladder appliances, and medications were reviewed and any additional identified deficits were corrected on 10/18/15 by the MDS team. 3. The facility has hired as second part time MDS nurse starting by 10/17/15. Education was completed with LSW team on 9/28/15 by National Campus RN consultant. DON educated the MDS team on the materials from the training by ND Dept. of Health on Sections E,G,M on the MDS 3.0 "The Journey Begins" on 10/14/15. The education also included Section I, H, and N from the RAI manual. The registered dietician and dietary manager have been educated by DON on 10/12/15 focusing on making sure that registered dietician and dietary manager assessments and documentation are accurate and in place as applicable to the look back periods. The facility has changed notification process to registered	

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 _____	09/24/2015

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 278	Continued From page 3 that are not problematic. These behaviors may indicate unrecognized needs, preferences, or illness. Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and interventions can be developed to improve the symptoms or reduce their impact . . . Steps for Assessment. 1. Review the medical record for the 7-day look-back period . . . Coding Instructions . . . Code 1, behavior of this type occurred 1-3 days . . . Code 2, behavior of this type occurred 4-6 days, but less than daily . . . Code 3, behavior of this type occurred daily . . ." - Review of Resident #5's medical record occurred on all days of survey. The resident's quarterly MDS, dated 08/07/15, identified verbal behaviors and rejection of cares which occurred one to three days during the seven-day look-back period. The record lacked specific evidence/documentation to verify episodes of verbal behaviors and rejection of care. The medical record showed canned template behavior documentation completed by the certified nursing assistants (CNAs). The documentation contained a heading such as "Physically Abusive Towards Others," however showed no evidence of the specific behavior(s) exhibited. Furthermore, the canned template documentation showed the CNAs determined/assessed whether the resident's behavior(s) put the resident at significant risk of physical illness or injury, whether the behaviors significantly interfered with the resident's care, and/or whether the behaviors significantly interfered with the resident's participation in activities or social interactions.	F 278	dietician on new skin issues. Effective 10/12/15, the dietary manager will notify the registered dietician of all new skin issues weekly and registered dietician assessments will be made as soon as possible. All issues of behaviors or refusals of care will now be reviewed by the IDT in morning clinical meeting effective 10/12/15. The infection preventionist and HIM nurse was educated by DON on 10/12/15 to review practiced going forward to update the diagnoses, infection reports, and care plans as indicated in them morning clinical meeting. The LSW and unit supervisors were educated on 10/12/15 by the DON to review all clinical alerts in the PCC dashboard in morning clinical meeting to ensure correct assessments/documentation are present on all behaviors and refusals of care. The unit supervisors were educated by DON on 10/12/15 on weekly updating the wound sheets /TARs and reviewing and revising wound care plans weekly. The DON educated lead nurses 10/12/15 that CMS 672 and 802 will be updated Monday and Friday to also identify and ensure applicable concerns related to survey findings are addressed to ensure our processes are further improved. 4. DNS or designee will audit to review MDS coding accuracy related to behaviors, active diagnoses, urinary tract infection diagnosis, nutrition or hydration intervention, bladder appliances, and medications. Audits will start on 10/16/15	

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 _____	09/24/2015

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 278	Continued From page 4 The CNA works under the supervision of a licensed nurse and is not allowed to make assessments or determinations of resident behaviors. Only the licensed nurse or provider can make these important determinations. ACTIVE DIAGNOSIS The Long-Term Care Facility RAI Manual, revised October 2014, page I-3 stated, "I: Active Diagnoses in the Last 7 days . . . This section identifies active diseases and infections that drive the current plan of care . . . 1. Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state license laws) in the last 60 days . . . 2. Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses . . ." - Review of Resident #5's medical record occurred on all days of survey and showed staff identified a Stage II pressure ulcer to Resident #5's coccyx on 07/19/15. The medical record indicated the pressure ulcer healed on 07/27/15.	F 278	and will be completed weekly X 4 weeks, then if in compliance, monthly X 3 months, then quarterly X 3 quarters. 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 _____	09/24/2015

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 278	Continued From page 5 A quarterly MDS, dated 08/07/15, incorrectly identified an "ulcer, pressure, buttock" as an "active diagnosis" during the 7-day look-back period. URINARY TRACT INFECTION DIAGNOSIS The Long-Term Care Facility RAI User's Manual, revised October 2014, page I-8 stated, "Item I2300 Urinary Tract Infection (UTI): The UTI has a look-back period of 30 days for active disease instead of 7 days. Code only if all the following are met: 1. Physician . . . diagnosis of a UTI in last 30 days. 2. Sign or symptom attributed to UTI, which may or may not include but not be limited to: fever, urinary symptoms (e.g. peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g. pyuria), 3. 'Significant laboratory findings' (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained) and 4. Current medication or treatment for a UTI in the last 30 days. . ." - Review of Resident #6's medical record occurred on all days of survey and identified a physician ordered laboratory tests, diagnosed, and treated the resident for a UTI on 06/30/15. The quarterly MDS, dated 07/13/15, failed to identify Resident #6's UTI. NUTRITION OR HYDRATION INTERVENTION The Long-Term Care Facility RAI User's Manual, revised October 2014, pages M-38 and M-39	F 278		

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 _____	09/24/2015

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 278	Continued From page 6 stated, ". . . M1200D Nutrition or Hydration Intervention to Manage Skin Problems: The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. . . . Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment . . . If it is determined that nutritional supplementation, i.e. [in example] adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and 'tailor nutritional supplementation to the individual's intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed,' . . ." - Review of Resident #1's medical record occurred on all days of survey. The admission MDS, dated 08/18/15, and the quarterly MDS, dated 04/14/15, identified nutrition or hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. - Review of Resident #3's medical record occurred on all days of survey. The significant change MDS, dated 08/02/15, identified nutrition or hydration interventions to manage skin problems. The medical record lacked an	F 278		

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 _____	09/24/2015

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 278	Continued From page 7 individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. - Review of Resident #5's medical record occurred on all days of survey. The quarterly MDS, dated 08/07/15, identified nutrition or hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. - Review of Resident #2's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 07/19/15, identified nutrition or hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. - Review of Resident #4's medical record occurred on all days of survey. The quarterly MDS, dated 03/29/15 and the annual MDS, dated 06/28/15, identified nutrition or hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. BLADDER APPLIANCES	F 278		

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 _____	09/24/2015

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 278	Continued From page 8 The Long-Term Care Facility RAI User's Manual, revised October 2014, page H-2 stated, ". . . H0100A, indwelling catheter (including suprapubic catheter and nephrostomy tube) . . . H0100C, ostomy (including urostomy, ileostomy, and colostomy) H0100D, intermittent catheterization . . . Coding Tips and Special Populations, Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C). . . ." - Review of Resident #2's medical record occurred on all days of survey. The facility admitted the resident on 04/20/15 with a suprapubic catheter in place. The admission MDS, dated 04/26/15, identified an indwelling catheter and an ostomy. The medical record lacked evidence of an ostomy. The quarterly MDS, dated 07/19/15, identified an indwelling catheter and intermittent catheterization. The medical record lacked evidence of intermittent catheterization. During an interview on the afternoon of 09/23/15 a nurse (#1) confirmed Resident #2 did not have an ostomy or intermittent catheterization. MEDICATION RECEIVED The Long-Term Care Facility RAI User's Manual, revised October 2014, page N-5 stated, ". . . N0410: Medication Received . . . 1. Review the resident's medical record for documentation that any of these medications were received by the resident during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). 2. Review documentation from other	F 278		

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 _____	09/24/2015

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 278	Continued From page 9 health care settings where the resident may have received any of these medications while a resident of the nursing home . . . N0410B, Antianxiety . . . N0410G, Diuretic . . ." - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included anxiety and hypertension (high blood pressure). The physician orders and Medication Administration Records (MARs) identified the resident received diazepam (an antianxiety medication) once daily since 01/15/15 and received spironolactone (a diuretic medication) once daily since 03/07/15. A quarterly MDS, dated 04/18/15, failed to identify Resident #7 received an antianxiety medication and a diuretic medication each day of the 7-day look-back period.	F 278		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:	F 356		10/13/15

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 _____	09/24/2015

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 356	Continued From page 10 o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to post accurate nursing staffing data and failed to post the data in a visible/available location on 3 of 3 days of survey (September 22-24, 2015). Failure to post accurate nurse staffing data denied residents and visitors the opportunity to be informed regarding the staffing levels. Findings include: Review of the facility policy titled, "NURSING STAFF DAILY POSTING REQUIREMENTS" occurred on 09/24/15. This policy, revised December 2014, stated, ". . . Nursing centers will post daily the staffing and resident census at the beginning of each shift and update as appropriate (for each shift). . . . This information must be prominently displayed in a clear and readable format where residents, staff and the public may view. . . ."	F 356	1. No residents were affected by this deficiency, as there were actually more staff on duty than posted at various times. Daily nursing staff data sheet is now posted in 4 visible/available locations readily accessible to residents and visitors. 2. Administrator, unit supervisors, department heads will all conduct daily monitoring to assure daily nursing staff data sheet is posted and visible. The HR/payroll clerk will assess weekly from the electronic time system to assure the hours are accurate. The staffing scheduler will audit daily nursing staff data sheet daily to ensure they are posted and accurate. 3. Administrator and DON educated the staffing scheduler on 10/12/15 as to her responsibility to keep the daily nursing	

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 _____	09/24/2015

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 356	Continued From page 11 Observations on all days of survey showed the daily nurse staffing information posted on a board in the north unit nurse's station (not visible/available for residents/visitors). During the initial staffing tour on 09/22/15 at 12:50 p.m., observation showed a certified nursing assistant (CNA) worked as a bath aide on the east/west unit. The CNA (#2) stated her shift started at 6:00 a.m. and she works until she completes all baths. On 09/21/15, she stated she worked until 4:00 p.m. to complete all scheduled baths. Review of the east/west unit daily nurse staffing information posted for 09/21/15 showed one bath aide worked 6:00 a.m. to 2:30 p.m. The facility failed to update the actual hours worked by the bath aide (6:00 a.m. to 4:00 p.m.). During an interview on 09/22/15 at 3:30 p.m., a CNA (#2) stated she had just ended her shift. Review of the east/west unit daily nurse staffing information posted for 09/22/15 showed one bath aide worked 6:00 a.m. to 2:30 p.m. The facility failed to update the actual hours worked by the bath aide (6:00 a.m. to 3:30 p.m.). During an interview on 09/22/15 at 4:10 p.m., a CNA (#4) stated the facility called her in at 8:30 a.m. to work the east/west unit. Review of the east/west unit daily nurse staffing information posted for 09/22/15 showed three CNAs worked 6:00 a.m. to 2:30 p.m, even though one CNA worked 8:30 a.m. to 2:30 p.m. The facility failed to update the actual hours worked by the CNAs.	F 356	staff data sheet posted and accurate. National campus HR consultant visited our facility week of 10/05/15 and is working on assisting the staffing scheduler how to implement the master on shift scheduler in an effort to make tracking easier, and taught her how to look at electronic time records to ensure accuracy. 7 department heads were educated by DON on 10/12/15 to monitor while on daily rounds to ensure daily nursing staff data sheet is posted and visible. DON educated staffing scheduler to post daily nursing staffing data sheet on yellow colored paper, so all would be able to identify it. Two plastic 8X10 picture frames were purchased for inserting daily nursing staffing data sheet, and these were placed at nurse's station in full view daily. On 10/13/15, the staffing scheduler educated other shift nurses how to keep daily nursing staffing sheet accurate every shift. 4. DNS or designee will audit nursing staff data sheet for daily posting and visible to residents and visitors. Audits will start on 10/16/15 and will be completed daily for 2 weeks, then weekly X 2 weeks, then monthly X 2 months, then quarterly X 3 quarters. 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 _____	09/24/2015

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 356	Continued From page 12 During the morning staffing tour on 09/23/15 at 8:30 a.m., observation showed a certified medication aide (CMA) (#5) on the north unit. The north unit daily nurse staffing information posted failed to show a CMA worked. During an interview on the afternoon of 09/23/15, a bath aide (#3) stated she worked 6:00 a.m. to 3:30 p.m. on the north unit. Review of the north unit daily nurse staffing information posted showed one bath aide worked 6:00 a.m. to 2:30 p.m. The facility failed to update the actual hours worked by the bath aide (6:00 a.m. to 3:30 p.m.).	F 356		