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

OMB NO. 0938-0391

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 _____	09/27/2012

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 09/24/12 and completed on 09/27/12, the sample included 3 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 225 SS=D	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.	F 225	1. Resident #16 – ~~No abuse or neglect occurred~~ Results of investigation sent to State 9/26/12. agency on 10/30/12. CNA # 12 terminated. per Dianne Lessman DON No incidence reoccurred. 10/30/12 - DL Care Plan was updated. Resident #5 sit to stand lift - per Dianne Lessman, DON CNA #13 terminated. 10/30/12 DL Nurse #10 No abuse or neglect occurred. No further incident after occurrence. Care plan updated after fracture femur. 2. All residents are at risk. No state reportable incidence since 6/2012. GSC has Critical Incident Notification (CIN) process for abuse and neglect reporting. All staff wills be educated on CIN process on 10/26/12 for nurses and 10/30/12 for all staff. 3. All staff meeting on 10/30/12 will review state reporting guidelines for reporting allegations of mistreatment, neglect and abuse, CIN report, and system changes. SYSTEM CHANGE: DNS, Administrator, Social Worker or designee is accountable for state reportable incident timely.	

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.

10-30-12

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 _____	09/27/2012

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 1 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. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of facility policy and procedure, the facility failed to report 1 of 2 alleged incidents of neglect and/or abuse to the State survey and certification agency immediately (within 24 hours) and failed to report the results of the investigations for 2 of 2 alleged incidents of neglect and/or abuse to the State survey and certification agency by the fifth working day of the initial report. Failure to report all alleged violations involving mistreatment, neglect, or abuse has the potential to place all residents at risk of possible neglect and abuse. Findings include: Review of the facility procedure titled "Abuse and Neglect" occurred on 09/26/12. This policy, revised January 2011, stated, "Purpose . . . To ensure all identified incidents of alleged or suspected abuse/neglect are promptly investigated and reported . . . to ensure that a complete review of existing incidents is documented . . . Procedure 5. Notification Procedures: c. Notify the designated agencies in accordance	F 225	F225 4. Audit tool will be completed weekly x4, monthly x2, then report of the audit findings will be reported to the QA Committee for further recommendations. Social Worker or her designee is responsible for completion of the audit. 5. November 1, 2012	

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 _____	09/27/2012

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 2	F 225		

with state law, including the state survey and certification agency. . . . Document the notifications on the Incident Report . . .
6. The investigation team (social worker, administrator and the director of nursing services) will review all Incident Report that involve residents including those that indicate an injury of unknown origin, abuse, neglect, misappropriation of resident property or involuntary seclusion no later than the next working day following the incident. . . .
9. The social worker or designated staff will report the results of all investigations to the state survey and certification agency and other officials within five (5) working days of the incident, unless otherwise specified by state law, whichever is stricter. . . ."

This policy conflicts with requirements, which state the facility must ensure all alleged violations are reported immediately to the administrator and other officials, not to exceed 24 hours after discovery of the incident.

- Review of the facility's investigations of alleged neglect and/or abuse, within the past year, occurred on the afternoon of 09/26/12 and the morning of 09/27/12. These allegations included the following incidents:

* Hand written investigation notes, dated 04/09/12, identified Resident #16 stated concerns regarding a certified nurse aid (CNA) (#12) not providing toileting cares and throwing a blanket at the resident. Documentation showed the facility initially reported this incident to the State survey and certification agency on 04/08/12. An administrative nurse (#10) completed the investigation on 04/09/12. Documentation

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 _____	09/27/2012

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 3 showed the facility had not reported the results of the investigation to the State survey and certification agency as of 09/27/12, 172 days after the initial report. * An "Incident Report," dated 06/19/12, identified a CNA (#13) transferred Resident #5 without the use of a stand lift, resulting in the resident falling and sustaining a femur fracture. Documentation showed the facility initially reported this incident to the State survey and certification agency on 06/21/12, over 24 hours later. Documentation showed the facility mailed the final report of the investigation to the State survey and certification agency on 09/06/12, 79 days after the incident occurred. During interviews on the afternoon of 09/26/12 and the morning of 09/27/12, an administrative nurse (#10) verified the facility did not submit a report for the investigation completed on 04/09/12, and failed to submit the final report for the 06/19/12 incident within five days.	F 225		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's instructions, and staff and pharmacist interview, the facility failed to ensure staff followed professional standards during 1 of 3 observations (Resident #2) of staff administering insulin using a NovoLog FlexPen. Failure to follow manufacturer's instructions regarding needle	F 281	1. Resident #2 Flex pen was used up and discontinued. New order for vials of insulin received and now in use. Resident will use more than 100 insulin syringes in one month. Extra needles needed will be supplied by the Center's house stock. 2. No other resident currently uses an insulin flex pen. House stock supply of insulin needles available for resident that uses more than three needles per day.	

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 _____	09/27/2012

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 4	F 281		

usage increases the risk of infection and/or inaccurate dosing.

Findings include:

Review of the NovoLog FlexPen manufacturer's instructions titled "Highlights of Prescribing Information" occurred on 09/26/12. The insert, dated 10/12/09, stated, "Always remove the needle after each injection and store the . . . NovoLog FlexPen without a needle attached. This prevents contamination and/or infection, or leakage of insulin, and will ensure accurate dosing. Always use a new needle for each injection to prevent contamination."

Observation of insulin administration for Resident #2 occurred on 09/24/12 at 5:50 p.m. A licensed nurse (#8) removed a NovoLog FlexPen from the medication cart. Observation showed a needle attached to the pen. The nurse stated, because Resident #2's insurance company only pays for one needle a day, she would be re-using the needle from the last dose administered. The nurse (#8) did not prime the needle, stating she primed it when she gave the prior dose.

A second observation of insulin administration for Resident #2 occurred on 09/25/12 at 10:10 a.m. A licensed nurse (#9) obtained a NovoLog FlexPen from the medication cart. Observation showed no needle attached to the pen. Prior to administration, the nurse obtained a new needle from the cart and attached it to the FlexPen. When asked if she reuses needles, the nurse stated, "No." The nurse (#9) stated the pharmacist (#11) has recommended that staff re-use needles "due to payment issues." The

3.
Education will be completed on 10/26/12. Staff informed Flex pen must have needle change each time.

4.
An audit tool developed on use of flex pen with insulin medication administration. QA coordinator or designee is responsible for the completion of the audit. Audit tool will be completed weekly x4, monthly x2, then report of the audit findings will be reported to the QA Committee for further recommendations

5. November 1, 2012.

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 _____	09/27/2012

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 5 nurse stated, "We haven't gone there yet." An interview with an administrative nurse (#10) occurred on 09/26/12 at 8:20 a.m. When asked about re-using needles for insulin pens, the nurse stated her expectation is that staff do not re-use needles. An interview with the pharmacist (#11) occurred on 09/26/12 at 12:50 p.m. The pharmacist (#11) stated Resident #2's insurance company will pay for 100 needles per month. Due to Resident #2's scheduled doses and sliding scale, she uses more than that each month. The pharmacist (#11) agreed the manufacturer recommends using a new needle for each dose.	F 281		
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: 1. Based on observation, record review, and staff interview, the facility failed to provide assistive devices necessary to prevent accidents for 1 of 1 sampled resident (Resident #5) who sustained a femur fracture during a transfer and 1 of 5 sampled residents (Resident #4) observed transported by staff in a wheelchair. Failure to utilize the sit to stand lift per the plan of care	F 323	1. Resident #5 - Transfer lift assessment completed and updated care plan to include the use of a Hoyer lift, no foot pedals needed. Resident #4 – Transfer lift assessment completed and updated care plan. Foot pedals available in a bag on the back of the wheelchair for staff to apply when assisting resident with wheelchair transport. CN ~~ACAN~~ #13 terminated. Resident #9 discharged to home on 9/27/12. 2. All residents that use wheelchairs, footrests, or mechanical lifts are at risk.	

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 _____	09/27/2012

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 6	F 323		

resulted in Resident #5 fracturing her leg, causing unnecessary pain, and a decline in the resident's mobility. Failure to apply foot pedals to wheelchairs during staff-assisted transport may result in falls and/or injury to residents.

Findings include:

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included general muscle weakness, arthropathy, and history of a femur fracture. Resident #5's annual Minimum Data Set (MDS), dated 04/10/12, and significant change MDS, dated 07/11/12, indicated transfer and toilet use with extensive assistance of two or more people. The 04/10/12 MDS indicated the resident walked in the corridor with extensive assistance of two or more people, and the 07/11/12 MDS indicated walking in the corridor did not occur.

Resident #5's Interdisciplinary Progress Notes (IDP), dated 06/19/12 at 9:05 p.m., stated, "GSS [Good Samaritan Society] #401 [Incident Report] filled out." The Incident Report, dated 06/19/12, stated, "Alleged nature of incident: Slipped or fell. . . . No injury . . . Comments: Staff attempted to transfer from w/c [wheelchair] to toilet by self, no lift used or gait belt. . . . Staff member given corrective action, and educated. . . ."

Resident #5's IDP notes, dated 06/20/12 at 1:05 p.m., stated, ". . . He [doctor] ordered a PT [Physical Therapy] post fall assessment. . . . Resident was not able to extend/assist [with] [left] L/E [lower extremity] for transfer. Resident reports pain [with] motion, swelling . . ."

2.
A list of residents on mechanical lifts and size of slings and a list of residents that use foot rests will be posted at each nurses station. A copy will be given to each department and all new staff so they know how to care for our residents.

A list of residents that smoke will be generated. One current resident smokes. The smoking assessment was completed on 9/25/12. Smoking apron available. Care plan updated. Resident is safe to smoke.

Another resident was assessed and found unsafe to smoke. MD started nicotine patch. Care plan updated.

3.
All staff education on ~~11/30/12~~ 10/30/12 - per Diane Learn from DON on 10/30/12 BL
a. foot rest, b. smoking procedure, c. mechanical lift and sling size.

New staff education on resident assistance. Transfer lift assessments are completed quarterly with the MDS schedule or with a change in the resident's ability to transfer.

4.
An audit has been developed to ensure compliance. Social worker or designee will complete the audit weekly x4, monthly x2, then report of the audit findings will be reported to the QA Committee for further recommendations

5.
November 1, 2012.

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 _____	09/27/2012

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 7	F 323		

A PT note, dated 06/20/12, stated, ". . . [Resident #5] has an edematous distal thigh and knee on the left. Her passive range of motion is limited to 20 degrees - 80 degrees. Sharp pain at the end ranges. Any dorsinal force on the femur produces pain in the knee and distal thigh. . . . She has pain with any attempted weight bearing. In fact, she cannot even use a sit to stand lift that would limit her weight bearing. She has to use a mechanical lift transfer . . . My recommendation is . . . get further diagnostic studies. . . ."

A PT note, dated 06/26/12, stated, ". . . [Resident #5] fell on 06/20/12 sustaining a distal femoral fracture of the left femur. She had an open reduction internal fixation [surgery] on 06/21/12 and returns to Good Samaritan now with orders to be non-weight bearing on the left. . . ."

Resident #5's care plan, dated 04/17/12, identified the following problems:
* "Altered bladder elimination r/t [related to] . . . mobility deficits . . . Plans and Approaches: Toilets with assist 2 with sit to stand lift . . ." On 07/03/12 staff updated the plan to read, "Toilets with assist 2 [with] hoyer lift to bed using bedpan . . ."
* "Impaired mobility/pot. [potential] falls r/t weakness and deconditioning, balance deficit, m/b [manifested by] unsteady gait, wears foot & ankle support, poor endurance, h/o [history of] falls/high risk for fall. . . . Plan and Approaches: . . . Transfers with sit to stand lift and assist of 2. . . ." On 06/27/12 staff updated the plan to read, "Transfers with total mechanical lift and assist of 2."
* "Cognitive loss r/t dx [diagnosis] dementia m/b

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 _____	09/27/2012

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 8	F 323		

memory deficit, and lack of judgement in decision making . . . Plans and Approaches: . . . Offer day to day cueing, explaination [sic] of ongoing cares, do not assume understands processes or procedures."

During an interview on 09/26/12 at 3:15 p.m., an administrative nurse (#10) stated the certified nurse aide (CNA) (#13) had completed orientation, but answered Resident #5's call light which was on a wing she had not previously worked on.

It was determined the facility failed to ensure the CNA (#13) was appropriately trained/educated to provide resident care consistent with the resident's care plan. This lack of training resulted in the resident's fall and fracture.

- Review of the medical record for Resident #4 occurred September 24-25, 2012. The facility identified diagnoses including hip fracture, arthritis, dementia, anxiety, and agitation. Resident #4's quarterly MDS, dated 08/19/12, identified moderately impaired cognition, extensive assistance of one person for transfer and dependence on one person for locomotion on/off the unit.

Observation on 09/25/12 at 8:30 a.m. showed a licensed nurse (#2) transporting Resident #4 out of the dining room in her wheelchair. Resident #4 slumped to the side and did not pick up her feet while being transported causing her feet to slide along the hard wood floor of the dining room. When the nurse (#2) reached the carpeted hallway, Resident #4's right foot caught and pulled backward under the wheelchair causing

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 _____	09/27/2012

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 9	F 323		

the top of her slipper to slide over the carpet. The surveyor asked the nurse (#2) to stop, indicating the unsafe positioning of the resident's foot. The nurse (#2) asked a CNA (#1) to lift Resident #4's feet while she pushed the resident. The CNA (#1) instead retrieved foot pedals and put them on Resident #4's wheelchair.

Observation on 09/26/12 at 8:15 showed a CNA (#14) helping Resident #4 with morning cares. The CNA (#14) identified the resident does not use foot pedals on her wheelchair. At the completion of cares, the CNA (#14) transported the resident to the dining room with the resident's shoes making a brushing noise as they slid along the carpet of the hallway.

During an interview on 09/26/12 at 7:55 a.m., an administrative nurse (#10) identified the facility staff would take steps to assure availability of foot pedals when needed by Resident #4.

2. Based on observation, record review, review of facility policy and guidelines, and staff interview, the facility failed to ensure the resident environment remained as free from accident hazards as possible, and failed to determine the resident's ability to safely smoke without supervision for 1 of 2 sampled residents (Resident #9) who smoked independently in an area outside the building. Failure to assess Resident #9's ability to safely smoke and ensure oxygen use is prohibited in the smoking area placed the resident, other residents, staff, and visitors at risk of injury.

Findings include:

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 _____	09/27/2012

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 10	F 323		

Review of the facility policy titled "Smoking" occurred on 09/27/12. This policy, revised April 2012, stated, ". . . Policy: . . . All clients who smoke or use tobacco products will be assessed. . . . Procedure: 1. . . . The program staff [coordinator] must ensure precautions are taken for the client's individual safety as well as the safety of others in the program. Smoking by clients when oxygen is in use is prohibited. A physician's order should be obtained allowing oxygen to be removed to allow a client to smoke. 2. It is required that all clients who smoke or use tobacco products should be assessed using the Tobacco Use Assessment (GSS #474) for safe use upon admission to the program and when staff members observe a change in safe practices. Each of the nine factors on the assessment should be considered in the care planning process. Care plans are updated as needed. . . ."

Review of the facility guidelines titled "Oxygen Use Safety" occurred on 09/27/12. These guidelines, revised March 2011, stated, "Purpose: To administer and store oxygen in a safe manner. Guidelines: 1. . . . There is always a danger of fire when oxygen is used. 2. Be sure to explain the hazards of smoking in the presence of oxygen to residents and families, i.e., resident who goes outside in wheelchair with oxygen. 3. No open flames or smoking in a room where oxygen is being used. . . . 7. Avoid use of flammable materials (. . . smoking . . .) near residents using oxygen.

Review of Resident #9's medical record occurred on September 25-27, 2012. The facility admitted the resident from the hospital on 09/14/12.

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 _____	09/27/2012

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 11	F 323		

Diagnoses included acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), congestive heart failure, and oxygen dependence. Resident #9's admission Minimum Data Set (MDS), dated 09/21/12, indicated intact cognition, independent locomotion on and off unit, and on oxygen therapy. Physician orders, dated 09/14/12, stated, "Oxygen to keep sats (oxygen saturation) [greater than] 90% [percent]." Resident #9's medication administration record (MAR) for September 14-26, 2012 showed staff charted the resident received oxygen at 2-3 liters per minute (L/M) daily with oxygen saturations of 90-95%. The physician orders failed to address the resident's tobacco habit and oxygen use while smoking.

Resident #9's nurses' notes, dated 09/19/12 at 5:00 p.m., stated, "Witnessed resident smoking a cigarette on front porch [with] O2 [oxygen] on per NC [nasal cannula] @ [at] 2.5 L/M. When approached he stated 'I'm going to smoke one no matter what' - I explained that he cannot smoke here [with] O2 running and he asked me to 'turn it off then.' . . . " The facility failed to complete a smoking assessment or develop a care plan and interventions related to smoking after this incident.

On 09/25/12 at 09:10 a.m., observation showed Resident #9 wheeled himself down the hall and out the front door. An unidentified resident was in this area smoking, along with two visitors who stopped to talk with the two residents. The resident had oxygen tubing in his nose connected to an oxygen tank with the pressure gauge reading between 1000 and 2000 pounds per square inch. Resident #9 lit and smoked 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 _____	09/27/2012

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 12 cigarette. An administrative staff member (#16) and an administrative nurse (#10) were informed of Resident #9's smoking. The nurse administrator stated the resident is supposed to stop at the nurses' station and have a nurse turn the oxygen off before he goes out to smoke. Resident #9's nurses' notes, dated 09/25/12 at 11:00 a.m., stated, "Wanderguard was placed on [name of resident]'s wheelchair so that when he goes outside to smoke, door will alarm so nurses can make sure oxygen is shut off. . . . " The facility failed to complete a smoking assessment to determine whether Resident #9 was safe to smoke unsupervised; failed to obtain a physician order regarding Resident #9's smoking and oxygen use; failed to develop a care plan and interventions related to smoking, oxygen use, and safety issues; and failed to ensure Resident #9 followed safety rules when smoking.	F 323		
F 333 SS=E	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 facility procedures and professional references, staff interview, and pharmacist interview, the facility failed to ensure residents remained free of significant medication errors for 3 of 12 sampled residents (Resident #2, #8, and #10) and 1 supplemental resident (#15). Failure to ensure staff administered the correct medication	F 333	1. Resident #2 – Diet changed for no carbohydrates to a regular level 4 CCD. Resident is non-compliant with diet, physician informed. Care plan updated. Insulin order revised. per Diane Lessman, DON 10/30/12 DL. Resident #8 – Risperdal was clarified by the MD. Resident is receiving correct dose of Risperdal. Resident #10 – Discontinued Lovestatin and started Uloric for gout. MAR updated. Foot pain has not changed with the med changes. Resident is on a pain management program. Resident #15 - Res is receiving the correct dose of Atenolol. per Diane Lessman, DON 10/30/12 DL	

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 _____	09/27/2012

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 13	F 333		

(Resident #8), at the correct dose (Resident #15), at the correct time (Resident #2), and discontinued the correct medication (Resident #10) placed the residents at risk of adverse consequences due to the errors. Failure to provide staff education following discovery of Resident #8's medication error contributed to additional medication errors for Resident #2, #10, and #15.

Findings include:

Review of the facility procedure "Physician's Orders" occurred on 09/27/12. The procedure, revised September 2010, stated, ". . . Physician's Orders - Content . . . Clarification orders are needed when reviewing any type of physician's orders that are incomplete or raise questions. . . . Physician's orders must be accurate at all times. Proper and timely maintenance of order changes will assist with ensuring accurate physician orders. . . . the licensed nurse must review for completeness and accuracy and obtain clarification if necessary. . . .
Discontinued Orders . . . A discontinued order may be received by a licensed nurse . . . The licensed nurse or designee will transcribe the orders per procedure . . . Enter 'D/C'd [discontinued],' the date, and initials of licensed nurse processing the order on the Medication Administration Record (MAR) . . . The remainder of the month should be lined through or highlighted. . . ."

Review of the facility procedure "Administration of Medication" occurred on 09/27/12. The procedure, revised October 2009, stated,

2.
All residents that receive meds are at risk.. Consultant pharmacist will monitor med pass monthly and review drug regimen for accuracy monthly.

3.
Staff education on 10/26/12 for all nurses on Physician orders procedure and administration of medication procedure. 'All nurses will complete the on-line in-service "Medication Administration – Avoiding common Errors".

SYSTEM CHANGE: Newly arrived meds will be reviewed for accuracy upon arrival.

4.
An audit tool has been developed to ensure compliance with procedures for acquisition of meds upon arrival to the Center, med pass, and error tracking.

All staff that pass medications will have another nurse watch a med pass for at least three residents. DNS or designee is responsible for completion of the audits. The audits will be completed weekly x4, monthly x2, then report of the audit findings will be reported to the QA Committee for further recommendations.

5.
November 1, 2012.

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 _____	09/27/2012

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 14	F 333		

"Purpose . . . To administer medications correctly using the center medication system. . . .
4. Using the specific center's medication system, administer medication to the resident according to the 'Five Rights:' Right drug, Right dose, Right route, Right time, Right resident . . .5. Be familiar with action and adverse reaction of medications. . . ."

- Review of the NovoLog FlexPen manufacturer's package insert titled "Highlights of Prescribing Information" occurred on 09/26/12. The insert, dated 10/12/09, stated, "Dosage and Administration . . . Subcutaneous Injection . . . Because NovoLog has a more rapid onset and a shorter duration of activity than human regular insulin, it should be injected immediately (within 5-10 minutes) before a meal. . . .
Warnings and Precautions . . . Hypoglycemia [low blood glucose level] is the most common adverse effect of all insulin therapies, including NovoLog. Severe hypoglycemia may lead to unconsciousness and/or convulsions and may result in temporary or permanent impairment of brain function or death. . . . Other factors such as changes in food intake (e.g. [such as] amount of food or timing of meals) . . . may also alter the risk of hypoglycemia. . . ."

Review of Resident #2's MAR for 09/25/12 identified staff administered a sliding scale dose (based on blood glucose levels) of 10 units NovoLog insulin at 7:00 a.m. for a blood glucose level of 334 mg/dl.

Observation, on 09/25/12 at 8:30 a.m., identified an administrative nurse (#10) entered Resident #2's room with an oxygen concentrator. The

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 _____	09/27/2012

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 15	F 333		

nurse stated Resident #2 was "having a bad morning" and identified the resident's blood glucose was 46 milligrams per deciliter (mg/dl). The nurse (#10) assisted Resident #2 to drink a glass of orange juice. Observation showed the resident groggy, but responding verbally and able to drink the juice without difficulty. During the observation an unidentified staff member entered the room with Resident #2's breakfast tray. Observation at 9:15 a.m. showed the resident consumed the entire breakfast.

The Interdisciplinary Progress Note regarding the event, dated 09/25/12 at 9:15 a.m., stated, "Nurse Manager called me to check on [Resident #2]. When I went in [Resident #2's] room, she was yelling, 'My sugar is low.' Accucheck [blood glucose monitor] was done & [and] it was 46 [mg/dl]. Orange juice and 2 packets of sugar was given at 8:20/a [a.m.] She then c/o [complained of] 'I can't breath.' O2 [oxygen] put on at 2 L [liters/minute]. At 8:30/a, Accucheck done & it was 59 [mg/dl]. Breakfast tray then came and she was eating it. At 8:40/a she stated 'I'm feeling better.' Accucheck done & it was 117 [mg/dl]."

Review of Resident #2's medical record occurred on all days of survey and identified a diagnosis of diabetes mellitus. The record identified the following:
* A physician's order, dated 06/14/12, stated, "Accu check QID [four times a day]. Use Novolog sliding scale with meals. . .."
* On 08/09/12 Resident #2 had a clinic appointment and returned with physician's orders to "Give 1 unit of Novolog [with] every 15 grams carbohydrates [after] meals. Give in addition to sliding scale."

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 _____	09/27/2012

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 16	F 333		

* On 08/09/12 at 3:51 p.m., the facility sent a fax to the physician requesting clarification of the above order. The fax stated, "I received your orders for covering carbs consumed with Novolog insulin - My question is - Resident eats at different times all day and all night - How many shots do you want her to have in a day? If we cover her before meals with sliding scale, she will have a shot and then if we count carbs [carbohydrates] [after] meals she will have to have another shot = can we check accu [check] before meals, do carb count of meal tray and give ONE shot [after] meals of needed novolog?"
* On 08/10/12 at 2:30 p.m. the physician's response stated, "[check] Accucheck before meal. Figure out how many grams of carbohydrate pt [patient] is about to consume & administer Novolog prior to meal based on sliding scale & estimated carbohydrate intake. Notify provider if you need further clarification."
* On 08/10/12 at 5:30 p.m. a nurse received clarification of the above order which stated, "[check] glucose levels tid [three times a day] b-4 [before] meals use sliding scale of Novolog as ordered but in addition give 1 unit of Novolog for each 15 Gm [grams] of carbohydrates consumed @ [at] that meal. Give the sliding scale and amt [amount] from carbs consumed after the meal."

Review of Resident #2's August 2012 MARs showed, starting on 08/11/12, staff performed Accuchecks tid at 6 a.m., 11 a.m., and 5 p.m. The MAR showed staff administered insulin at those times in accordance with the Accucheck results. The MAR also identified, starting on 08/11/12, staff administered insulin at 9 a.m., 1 p.m., and 7 p.m., in accordance with the resident's carbohydrate intake at meals. Although

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 _____	09/27/2012

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 17	F 333		

the MAR stated "[after] meals" for both the sliding scale and carbohydrate coverage doses, the MAR identified staff administered a separate injection for each, rather than combining the doses, as per physician's orders.

A review of Resident #2's September MAR occurred on 09/25/12 at 4:40 p.m. with a licensed nurse (#9). The MAR identified nurses performed accuchecks and administered insulin at 7 a.m., 11 a.m., and 5 p.m. daily and performed carbohydrate counts and administered insulin again at 9 a.m., 1 p.m., and 7 p.m. daily, rather than combining the doses in one after meal dose, as the physician ordered. The nurse (#9) stated the physician's orders were "confusing."

Observation of insulin administration for Resident #2 confirmed staff continued to administer insulin both before and after meals:
* On 09/24/12 at 5:50 p.m. a licensed nurse (#8) administered a sliding scale dose prior to the meal.
* On 09/25/12 at 10:10 a.m. a licensed nurse (#9) administered a dose to cover the resident's carbohydrate intake only following the meal.

Observation and review of Resident #2's MARs for August and September 2012 identified, despite the above physician's order to combine the sliding scale and carbohydrate coverage doses in one injection given after each meal, staff continued to administer the sliding scale dose before meals and the carbohydrate coverage dose after meals. This resulted in the resident receiving up to three extra injections each day from August 11 - September 25, 2012. Failure to ensure staff administered the insulin sliding scale

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 _____	09/27/2012

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 18	F 333		

dose after the meal resulted in the resident experiencing a hypoglycemic episode on 09/25/12 and placed the resident at risk for loss of consciousness and seizures.

- "Nursing 2011 Drug Handbook," 31st edition, Lippincott, Williams and Wilkins, Philadelphia, pages 646-647, reviewed on 09/27/12, identifies Ropinirole as an antiparkinson medication which may be used for moderate to severe restless leg syndrome and states ". . . Adults: Initially, 0.25 mg [milligrams] P.O. [by mouth] 1 to 3 hours before bedtime. May increase dose as needed and tolerated after 2 days to 0.5 mg . . . ADVERSE REACTIONS . . . CNS [Central Nervous System]: dizziness, fatigue . . . hallucinations . . . PATIENT TEACHING . . . Inform patient (especially elderly patient) that hallucinations can occur. . . .;" and, pages 677-680, identifies Risperdal as an antipsychotic medication which may be used for treatment of irritability, including aggression.

Review of Resident #8's medical record occurred on September 24-27, 2012. The facility admitted the resident in April 2010. The resident's current diagnoses include dementia. The resident's Cognitive Loss/Dementia Care Area Assessment, dated 04/05/12, stated "The resident has dx [diagnosis] of senile dementia with depressive features and dementia is advanced with significant cognitive impairment. . . ."

Resident #8's Interdisciplinary Progress Notes stated the following:
*05/25/12, 1:00 p.m. - "[Consultant psychiatrist] visits for psych. [psychiatric] followup, new orders received."

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 _____	09/27/2012

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 19	F 333		

*06/22/12, 11:00 a.m. - "[Consultant psychiatrist] visits at facility for followup. New orders received. [Increase] Risperdal to 1 mg. p.o. qhs [every bedtime]."
*06/22/12, 2:00 p.m. - "When doing order change I found that pharmacy had sent Ropinirole [on] 05/26/12 instead of Risperidal [sic] et [and] the Ropinirole is what has been given. [Consultant psychiatrist] here and changed order back to Risperdal 0.5 mg. qhs."

Resident #8's physician orders stated the following:
*05/25/12, "Risperdal 0.5 mg qhs."
*06/22/12, "[Increase] Risperdal to: Risperdal 1 mg. 1 p.o. qhs."
*06/22/12, "1. DC [Discontinue] Risperdal 1 mg qhs. 2. Start Risperdal 0.5 mg qhs."

Resident #8's medical record included the facility's Incident Report, dated 06/22/12 at 3:30 p.m., which stated ". . . D. CONTRIBUTING FACTORS: . . . Comments: Ropinirole 0.5 mg. sent from Pharmacy and was used which was the wrong drug. Resident was suppose to get Risperdal 0.5 mg. qhs which is a med. [medication] error. . . . G. . . . What immediate interventions have been put in place to prevent this incident from happening again? . . . Nurse to [check] meds [medications] more carefully [before] giving to resident. . . ." The Incident Report identified the facility notified the consultant psychiatrist, the resident's physician, and the resident's responsible party of the medication error.

Review of Resident #8's medication administration record (MAR) identified 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 _____	09/27/2012

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 20	F 333		

staff provided "Risperdal 0.5 mg. qhs" to the resident for the period May 26, 2012 to June 22, 2012.

Resident #8's Behavior Documentation and Interdisciplinary Progress Notes for the period May 02-25, 2012 identified three episodes of agitated behaviors; and, for the period May 26-June 22, 2012 identified five episodes of agitated behaviors, including striking at residents, staff, and visitors, thought staff person was a monkey (06/04/12), and thought there was a fire in her room (06/07/12).

During interview, on 09/26/12 at 8:20 a.m., an administrative nursing staff member (#10) reported the pharmacy provided the medication "cartridge" labeled "Ropinirole 0.5 mg" and facility staff did not read the label closely and recognize the difference with "Risperdal 0.5 mg." until 06/22/12. This staff member (#10) reported the facility staff notified the pharmacy at the time of the discovery of the error, corrected the medication at that time, and the facility provided staff education by placing a note on the MAR to remind staff to read the medications closely.

Failure to provide the correct medication as ordered may have resulted in Resident #8 experiencing hallucinations as a side effect of the Ropinirole, may have resulted in Resident #8's increased behaviors towards other residents, visitors, and staff, and may have resulted in Resident #8 receiving an increased dose of the antipsychotic medication Risperdal on 06/22/12.

- "Nursing 2011 Drug Handbook," 31st edition, Lippincott, Williams and Wilkins, Philadelphia,

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 _____	09/27/2012

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 21	F 333		

pages 792-793, identified Uloric as a musculoskeletal system drug used for the treatment of high uric acid levels associated with gout.

Review of the medical record for Resident #10 occurred September 24-25, 2012. The facility admitted the resident in June 2012 and identified diagnoses that included gout. A physician order, dated 07/18/12, stated "Uloric 40 mg po [by mouth] qd [every day]."

Review of the MAR for Resident #10 showed facility staff failed to administer the Uloric from 08/06/12 to 08/31/12, a period of 26 days.

A fax to the physician, dated 09/01/12, stated "It came to my attention today that [Resident #10] has not been receiving Uloric 40 mg daily since 8/6/12. Nurse mistakenly d/c'd [discontinued] this med instead of Lovastatin that was ordered. We will restart the Uloric today unless I hear otherwise from you." The physician replied "Restart Uloric today."

The investigation section of an "Incident Report," dated 09/05/12, stated "A. GENERAL INFORMATION: Date Incident Occurred 08/05/12, Time Occurred 8 [8:00] p.m., Date Incident Reported 09/01/05 . . . C. ALLEGED NATURE OF INCIDENT: . . . Medication . . . Omission . . . D. CONTRIBUTING FACTORS: . . . Comments: sticky note on mar [Medication Administration Record] over med [medication] stated when supply gone start provastatin. No name specified on note but was over Uloric. Upon review was ordered to stop Lovastatin when done and start provastatin. . . . G . . . What immediate

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 _____	09/27/2012

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 22	F 333		

interventions have been put in place to prevent this incident from happening again? . . . all appropriate in place . . ." The "Incident Report" identified the facility notified the resident's physician and family concerning the omission of this medication.

Review of Resident #10's medication administration record showed during the time she did not receive the Uloric she requested medication for foot/leg pain on five occasions. The resident had not requested pain medication for foot/leg pain during June and July 2012.

During an interview on 09/27/12 at 8:05 a.m., an administrative nurse (#10) provided no additional information concerning the omitted medication for Resident #10.

- Review of Resident #15's medical record occurred on 09/25/12. Diagnoses included hypertension. A medication order, dated 03/16/06, included "Atenolol 50 mg [milligrams] po [orally] QD [every day] in AM and 25 mg QD in PM."

On 09/25/12 at 7:50 a.m., a licensed nurse (#9) retrieved a medication cassette from the medication cart. The pharmacy label on the cassette indicated the medication was "Atenolol 25 mg." Five tablets remained in the cassette after the nurse (#9) administered one 25 mg tablet to Resident #15.

Later on the morning of 09/25/12, a licensed nurse (#9) verified Resident #15 received Atenolol 25 mg instead of the ordered 50 mg. The nurse checked the cassette with the Atenolol, and

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 _____	09/27/2012

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 23 noted a handwritten strip of paper on the top edge of the cassette which said "Atenolol 50 mg." This nurse stated the pharmacist or a nurse labeled the top edge of the cassette incorrectly. The nurse stated facility staff call the pharmacist with the prescription number when a medication needs to be refilled and the pharmacy sends a replacement cassette. The nurse checked the p.m. Atenolol cassette and it contained 25 mg tablets. This nurse checked the medication storage cupboard and could not find any cassettes with Atenolol 50 mg. During an interview on 09/26/12 at 12:55 p.m., the pharmacist (#11) who fills Resident #15's medications stated the resident only received the Atenolol 25 mg tablets for at least 25 doses. Review of Resident #15's sitting blood pressure in August 2012 ranged from 111/48 to 138/68, and showed an increase to 146/62 to 150/88 in September. Staff error in providing half the morning dose of Atenolol may have contributed to this increase in blood pressure.	F 333		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425	I. Resident #8 – dose of Risperdol clarified by MD - per Diane Lee RN 10/30/12 DL Resident is receiving the correct dose of Risperdol. *See F333. Resident #15 – Atenolol dose clarified by MD and resident is receiving the correct dose. *See F333	

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 _____	09/27/2012

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 425	Continued From page 24	F 425		

administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure accurate receipt, dispensing, and administration of medications for 1 of 12 sampled residents regarding the correct medication (Resident #8) and 1 supplemental resident (Resident #15) regarding the correct dose. Failure to ensure the pharmacy provided the correct medication may have resulted in Resident #8 experiencing hallucinations and demonstrating increased behaviors towards staff, visitors, and other residents; and, may have contributed to Resident #15's increased blood pressure.

Findings include:

Review of the facility policy and procedure, "Pharmaceutical Services," occurred on 09/27/12. This document, revised January 2009, stated "PURPOSE, To provide appropriate and timely pharmacy service to residents. POLICY . . . These services will be provided to meet the needs of each resident (including procedures that assure the accurate acquiring, receiving,

2.
All residents that receive meds are at risk. Consultant pharmacist to do monthly med pass audit on 3-5 residents per month.

3.
Education on 10/26/12 to the staff that pass medications on the procedure for Pharmaceutical Services. Ensure accurate acquisition, receipts, dispensing on all meds and biologicals.

4.
An audit was developed to ensure compliance. DNS or designee will complete the audit weekly x4 weeks, monthly x2 months. Results will be reported to the QA Committee for further recommendations.

5.
November 1, 2012.

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 _____	09/27/2012

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 425	Continued From page 25	F 425		

dispensing and administering of all medications and biologicals). . . . A licensed Pharmacist will be employed or services obtained to:
1. Provide consultation on all aspects of pharmacy services.
2. Establish a system of records of receipt and disposition of all controlled medications . . .
3. Determine that medication records are in order . . ."

- Review of Resident #8's medical record occurred on September 24-27, 2012. The resident's current diagnoses include dementia. (Refer to F333).

Resident #8's Interdisciplinary Progress Notes stated the following:
*05/25/12, 1:00 p.m. - "[Consultant psychiatrist] visits for psych. [psychiatric] followup, new orders received [Risperdal 0.5 mg qhs]."
*06/22/12, 11:00 a.m. - "[Consultant psychiatrist] visits at facility for followup. New orders received. [Increase] Risperdal to 1 mg. p.o. qhs [every bedtime]."
*06/22/12, 2:00 p.m. - "When doing order change I found that pharmacy had sent Ropinirole [on] 05/26/12 instead of Risperidal [sic] et [and] the Ropinirole is what has been given. [Consultant psychiatrist] here and changed order back to Risperdal 0.5 mg. qhs."

Resident #8's medical record included the facility's Incident Report, dated 06/22/12 at 3:30 p.m., which stated ". . . D. CONTRIBUTING FACTORS: . . . Comments: Ropinirole 0.5 mg. sent from Pharmacy and was used which was the wrong drug. Resident was suppose to get Risperdal 0.5 mg. qhs which is a med.

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 _____	09/27/2012

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 425	Continued From page 26	F 425		

[medication] error. . . ."

Resident #8's Behavior Documentation and Interdisciplinary Progress Notes for the period May 02 - 25, 2012 identified three episodes of agitated behaviors; and, for the period May 26 - June 22, 2012 identified five episodes of agitated behaviors, including striking at residents, staff, and visitors, thought staff person was a monkey (06/04/12), and thought there was a fire in her room (06/07/12).

During interview, on 09/26/12 at 8:20 a.m., an administrative nursing staff member (#10) reported the pharmacy provided the medication "cartridge" labeled "Ropinirole 0.5 mg" on 05/26/12. This staff member (#10) reported the facility staff notified the pharmacy at the time of the discovery of the error, on 06/22/12, and corrected the medication at that time.

Failure to provide the correct medication as ordered may have resulted in Resident #8 experiencing hallucinations as a side effect of the Ropinirole, may have resulted in Resident #8's increased behaviors towards other residents, visitors, and staff, and may have resulted in Resident #8 receiving an increased dose of the antipsychotic medication Risperdal on 06/22/12.
- Review of Resident #15's medical record occurred on 09/25/12. Diagnoses included hypertension. A medication order, dated 03/16/06, included "Atenolol 50 mg [milligrams] po [orally] QD [every day] in AM and 25 mg QD in PM." (Refer to F333).

On 09/25/12 at 7:50 a.m., a licensed nurse (#9) administered one pill to Resident #15 from 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 _____	09/27/2012

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 425	Continued From page 27	F 425		

medication cassette with a pharmacy label stating "Atenolol 25 mg." Later on the morning of 09/25/12, a licensed nurse (#9) verified Resident #15 received Atenolol 25 mg instead of the ordered 50 mg. The nurse checked the cassette with the Atenolol, and noted a handwritten strip of paper on the top edge of the cassette which said "Atenolol 50 mg."

During an interview on 09/26/12 at 12:55 p.m., the pharmacist who fills Resident #15's medications stated the resident only received the Atenolol 25 mg tablets for at least 25 doses.

Review of Resident #15's sitting blood pressure in August 2012 ranged from 111/48 to 138/68, and showed an increase to 146/62 to 150/88 in September. Pharmacy error in providing the cassette with the incorrect morning dose of Atenolol and with conflicting labels may have contributed to this increase in blood pressure.

F 441 SS=B — 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS — F 441

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective

1.
Resident #16 – Staff are not touching resident's finger foods during meals. Gloves are available for staff to use.

2.
Residents that require assist at meals have the potential to be at risk. The listed residents will be audited with the audit tool.

3. Education on 10/30/12 for all staff on food handling techniques with a post test.

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 _____	09/27/2012

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 28	F 441		

actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to ensure a sanitary environment regarding bare hand contact with residents' food items by three unlicensed and two licensed staff members assisting four residents during 2 of 4 meal observations (breakfast meals on 09/25/12 and 09/26/12). Bare hand contact with residents' ready-to-eat food items has the potential for the transmission of disease and infection.

Findings include:

Observation in the facility dining room identified

4.
An audit was developed to ensure staff do not touch food with their hands.

Infection Control nurse or designee will complete the audit weekly x4 weeks, monthly x2 months. Results will be reported to QA for further recommendations.

5.
November 1, 2012.

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 _____	09/27/2012

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 29	F 441		

the following:
*09/25/12, 8:40 a.m., breakfast meal -
- A certified nursing assistant (CNA) (#1) picked up a half slice of toast with her bare hands and held it to an unidentified resident's mouth. The resident took a bite of the toast.
- A licensed nursing staff member (#2) picked up a half slice of jellied buttered toast with her bare hands, folded it in half and handed it to an unidentified resident.
- A licensed nursing staff member (#4) provided toast to Resident #16 with her bare hand.
- An unidentified CNA (#5) provided toast to Resident #16 with her bare hand.
*09/26/12, 8:30 a.m., breakfast meal -
- A CNA (#6) provided toast to an unidentified resident with her bare hand.

During an interview, on 09/26/12 at 2:37 p.m., an administrative dietary staff member (#3), identified the facility expects no bare hand contact with foods when staff assist residents to eat.

F 454 SS=D — 483.70 LIFE SAFETY FROM FIRE — F 454

The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.

This REQUIREMENT is not met as evidenced by:
Based on observation, review of facility policy, review of professional reference and staff interview, the facility failed to store oxygen according to current Life Safety Code requirements in 1 of 2 oxygen storage rooms (East/West wing). Failure to store the oxygen

1.
No resident was cited. Oxygen in clean storage on E/W hall is now secured.

2.
All residents have the potential to be affected by unsecured oxygen tanks. All E-tanks in use will be checked for security.

3.
Education on the procedures & guidelines for oxygen safety will be completed on 10/30/12

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 _____	09/27/2012

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 454	Continued From page 30	F 454		

tank in a secure manner has the potential for the tank to fall and become a projectile missile potentially causing injury to residents, visitors, and staff.

Findings include:

Life Safety Code requirements state, "Nonflammable medical gas systems and equipment used for the administration of inhalation therapy and for resuscitative purposes comply with NFPA 99, 13-5.1, 7-1.2, NFPA 70."

Standard for the Storage, Use, and Handling of Compressed Gases and Cryogenic Fluids in Portable and Stationary Containers, Cylinders, and Tanks, NFPA 55, 7.1.4.4 states "Securing Compressed Gas Containers Cylinders, and Tanks. Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling (collect/gather) them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted by 7.1.4.4.1 and 7.1.4.2.7."

Review of the facility policy titled "Guidelines Oxygen Use Safety" occurred on 09/27/12. The policy, dated 3/11, stated, "Purpose: To administer and store oxygen in a safe manner. . . . 12. All oxygen cylinders and concentrators will be stored in clean, controlled area. 13. All oxygen cylinders should be chained in place, racked or stored in stable carts at all times. . . ."

Observation of oxygen storage occurred with a staff nurse (#7) on 09/25/12 at 2:15 p.m. Observation showed a free-standing oxygen tank

4.
An audit was developed to monitor oxygen security. The audit will be completed weekly x4 weeks, then monthly x2 months. DNS or designee will be responsible for completion of the audit. Audit results will be reported to QA Committee for further recommendations.

5.
November 1, 2012

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 _____	09/27/2012

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 454	Continued From page 31 on the floor in the clean storage room of the East/West wing. The oxygen tank lacked any method of corralling or securing it. The clean storage room contained a rack holding oxygen tanks with storage space available. During an interview at the time of the observation, the staff nurse (#7) confirmed staff are to store oxygen cylinders in the rack provided.	F 454	**General Disclaimer** Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth 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 allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	