STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CROSBY	705 SE 4TH ST CROSBY, ND 58730

(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 07/16/12 and completed on 07/18/12, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000	*Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.* F280:	
F 280 SS=B	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to review and revise	F 280	1. A.) Resident #5's wander guard was discontinued on 7/19/2012. The Care Plan was updated on 08/10/2012 to reflect the discontinued wander guard, history of falls, and low bed in place while resident is in bed. B.) Resident #6's care plan was updated on 7/19/2012 to reflect that she needs ace wraps instead of Ted hose. The care Plan was also updated on 8/10/2012 clarifying that the right hearing aide was found and a new left aide is in the process of being replaced. Use of a wedge cushion to aide in repositioning was also updated on the care plan 8/10/2012. C.) Resident #2's Care Plan was updated to reflect the nutritional supplements being offered do to skin breakdown on 7/19/2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: J. Stu
TITLE: Administrator
(X6) DATE: 8/17/2012

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CROSBY	705 SE 4TH ST CROSBY, ND 58730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 1 the comprehensive care plan for 5 of 9 sampled residents (Resident #2, #4, #5, #6, and #9). Failure to review and revise the resident care plans limited the staff's ability to communicate the care needs of each resident and limited the staff's ability to ensure continuity of care for each resident. Findings include: - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and pain. The admission Minimum Data Set (MDS), dated 05/04/12, identified Resident #5 required extensive assitance of two or more staff members for locomotion on and off the unit and no behaviors present. Resident #5's current care plan stated, "Problem: Alteration in thought process . . . Hx [history] of attempts to leave the building . . . Monitor for elopement attempts . . . wanderguard in place . . ." A physician's order, dated 05/09/12, stated, "DC [discontinue] wanderguard." Review of the progress notes identified Resident #5 experienced falls on 05/14/12 and 06/23/12 and weakness/unable to stand on 06/24/12, 06/25/12 06/27/12, 07/03/12, and 07/04/12. Observation showed when facility staff placed Resident #5 in her bed, they positioned the bed in the lowest position. The facility failed to identify a history of falls and a	F 280	D.) Resident #9's Care Plan was updated on 08/10/2012 to reflect the use of low bed and fall mattress in place while resident is in bed the tab alarm was added to the residents' door. The care plan was updated on 7/19/2012 to indicate our use for this as a protective measure for staff awareness. E.) Resident #4 is currently using a low bed when in bed and a wedge cushion to be used prn to aide in repositioning. Care plan was updated on 8/10/2012. 2. All residents could be affected. The Care Plan team will review all SNF care plans to ensure they are updated. The residents' care plans will be reviewed utilizing the MDS cycle to ensure they reflect the most current interventions. HIM will monitor daily care plan interventions and nursing will update the care plan when a new intervention is noted prior to the next care conference.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CROSBY	705 SE 4TH ST CROSBY, ND 58730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 2 low bed on Resident #5's care plan and failed to revise the care plan when the resident's physician discontinued the wanderguard. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia and edema. Resident #6's current care plan stated, "Problem: Potential for injury . . . history of falls . . . Approaches: . . . low bed/fall mat . . . Problem: Audio deficit . . . HA's [hearing aids] missing as of 11/22/11 . . . Problem: Potential for skin breakdown . . . TED hose [compression stockings to help with edema in the lower legs] on AM - off PM . . ." Observation on 07/17/12 at 9:30 a.m. showed a hearing aid in Resident #6's right ear and her lower legs wrapped with ace-wrap bandages. Observation at 2:30 p.m. showed the resident in bed, positioned on her left side with a wedge cushion, the bed in a low position, and a fall mat in place. The facility failed to identify the use of a wedge cushion and ace-wrap bandages on Resident #6's care plan, and failed to revise the care plan after finding the resident's hearing aid. - Record review for Resident #2 occurred on all days of survey. Medical diagnoses included a Stage II pressure ulcer to the coccyx. The current MDS, dated 06/24/12, identified a current Stage II pressure ulcer and interventions which included nutrition or hydration. Observation of the noon meals on 07/17/12 and 07/18/12 showed Resident #2 received nutritional	F 280	3. A **system change:** HIM personnel will initiate a carbon copy reminder form when new orders are received that may require a care plan change. This reminder form will start with the HIM staff to the Nursing Staff. The nursing staff will be responsible to make the care plan changes. The reminder form is then sent to the DNS to double check the care plan to ensure the new intervention has been added, and then the form is routed back to HIM staff and she will shred the reminder audit once the care plan changes have been made. Education will be completed by 8-23-2012 to all licensed nurses on how to use the reminder audit and on the need to keep care plans current in order to communicate the care plan interventions with the direct care giver and to prevent falls with the proper use of low beds with fall mat, discontinued wander guard, use of hearing aides, use of wedge cushions, and proper use of alarms to prevent resident falls. 4. A Care Plan audit will be developed to randomly audit 5 residents. The DNS or her designee is responsible for the completion of the audits. The audits will be done weekly x 1 month, monthly x 2 months, then quarterly there after. Results of the audits will be reported and discussed at monthly QA meetings for further recommendations. 5. Completion date: August 27, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CROSBY	705 SE 4TH ST CROSBY, ND 58730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 3 supplements with her meals. The current care plan did not identify nutritional supplements as one of the interventions to aid in the healing of Resident #2's pressure ulcer. - Record review for Resident #9 occurred on 07/18/12. Medical diagnoses included dementia with behaviors and a history of falls with a fracture to the left hip. The current MDS, 05/17/12, identified severe cognitive impairment and falls without injury since admission. Observation on 07/18/12 showed Resident #9 had a low bed, a fall mat when in bed, and a tab alarm on her door to alert staff when the resident entered her room for monitoring purposes. The current care plan did not identify the low bed, fall mat, or tab alarm to the resident's door among the current interventions for falls. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included generalized pain, osteoarthritis, dementia, and a current Stage 2 pressure ulcer to her coccyx. The quarterly MDS, dated 05/03/12, identified extensive assistance of two or more staff members for bed mobility, a Stage 2 pressure ulcer, and no falls. Observation during all days of survey showed Resident #4 had a low bed and staff used a wedge cushion to position Resident #4 while she was in bed. The current care plan, stated, "Problem: Potential for injury R/T [related to] arthritis & [and]	F 280	See audit #1 for F 280	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CROSBY	705 SE 4TH ST CROSBY, ND 58730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 4 dementia M/B [manifested by] hx [history] falls . . . Approaches: Transfer her to recliner when she requests it . . . Problem: Potential for skin breakdown R/T osteoarthritis and fragile skin M/B stiff when moving and needs ext. [extensive] assistance with repositioning. Stage 2 to coccyx (R) [right] inner buttocks . . . Approaches: Reposition Q [every] 2-3 HRS [hours] and PRN [as needed] . . . cushion in chair and . . . mattress . . ." Resident #4's care plan failed to identify the use of a low bed and wedge cushion. During an interview on the morning of 07/18/12, an administrative nurse (#1) agreed staff should update the care plans to reflect the most current interventions.	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, and staff interview, the facility failed to provide the necessary interventions (repositioning and monitoring) for 2 of 5 sampled	F 314	F314 1. Resident #2 and #4 will have their individual needs met by updating their Care Plan approaches in resident services to have the staff start documenting the care plan intervention as completed or refused in the electronic medical record. 2. All residents with a braden scale of 18 or less or if they are listed on the monthly pressure ulcer report are at risk to be affect in this area. All residents triggered will have their care plans reviewed for current skin intervention.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CROSBY	705 SE 4TH ST CROSBY, ND 58730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 5 residents (Resident #2 and #4) with current pressure ulcers. Failure to provide interventions in accordance with the residents' plan of care may slow or prevent healing of current pressure ulcers and places residents at risk of developing new pressure ulcers. Findings include: Review of the facility policy titled "Pressure Ulcer Practice Guidelines" occurred on 07/18/12. This policy, revised September 2010, stated, ". . . Wound Assessments . . . It is recommended that the nursing progress notes reflect the nurse's observation and management of wounds from a shift to shift perspective and with each dressing change. At a minimum, weekly documentation is recommended to provide a review of the pressure ulcer/wound. Weekly documentation should include the date observed and: . . . * Measurements . . . * Presence, type, color, odor, appearance and approximate amount of any exudate . . . * Wound bed characteristics . . . Prevention Strategies . . . The nurse aide is also responsible for implementing certain preventative interventions for the resident based on the resident's plan of care and should be educated by the nurse on how to perform these interventions . . . Staff should implement resident specific turning and positioning programs based upon an individualized assessment. This includes a consistent program for changing the resident's position and realigning the body . . ." - Record review for Resident #2 occurred on all days of survey. Medical diagnoses included	F 314	3. An all staff meeting presented by the physical therapist will be held on August 27, 2012 to educate the staff on repositioning techniques. A demonstration will be provided for all staff that document in the kiosk on the expectation that they will need to start documenting in the care plan module on the kiosk how to document an intervention as completed or refused. 4. An Audit will be developed to monitor at risk residents identified above and other resident pulled at random. The Director of Nursing or designee is responsible for the completion of the audit. The Audit will be done weekly x 1 month, monthly x 2 months. The results of the audits will be reported and discussed at monthly QA meetings for further recommendations. 5. Completion date: August 27, 2012.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CROSBY	705 SE 4TH ST CROSBY, ND 58730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 6	F 314	See audit #2 for F 314	

osteoporosis, kyphosis, pain, and a Stage II pressure ulcer to the coccyx. The current Minimum Data Set (MDS), dated 06/24/12, identified moderate cognitive impairment, extensive assistance with bed mobility and transfers, a current Stage II pressure ulcer, and the following interventions: pressure reducing device for chair, pressure reducing device for bed, nutrition or hydration intervention, pressure ulcer care, and application of nonsurgical dressings. Further record review showed a history of Stage I pressure ulcers to the left coccyx and sacrum.

The current care plan stated, ". . . Potential for skin breakdown R/T [related to] inability to move herself . . . fragile skin . . . open areas to (R) [right] and (L) [left] ischium and (L) ischial tuberosity . . . Reposition Q [every] 2-3 hours and prn [as needed] as resident allows - often refuses. . . . 07/09/12. Drsg, [dressing] to Stage I (L) ischial tuberosity. . . . Encourage her to sleep in her bed . . ."

Review of the current wound flow sheets identified one of two Stage I pressure ulcers to the left ischium healed and a Stage II pressure ulcer to the right ischium with the following measurements:
* 06/26/12 - 0.75 centimeters (cm) in diameter
* 07/04/12 - 0.50 cm in diameter
* 07/16/12 - 1.0 cm in diameter

During an interview on 07/17/12 at 10:05 a.m., a nurse (#4) stated the nursing staff monitors and measures the resident's pressure ulcers on a weekly basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CROSBY	705 SE 4TH ST CROSBY, ND 58730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 7	F 314		

The above wound documentation demonstrates a twelve day time span between 07/04/12 and 07/16/12, during which time Resident #2's pressure ulcer on the right ischium increased in size from 0.5 cm to 1.0 cm. in diameter.

Observation throughout the survey showed Resident #2 sitting in her wheelchair or sleeping in her recliner. During toileting on 07/17/12 at 2:00 p.m., two certified nurse assistants (CNAs) (#5 and #6) assisted Resident #2 to lie down in bed and repositioned her onto her left side. Observation showed the resident did not refuse lying down or repositioning. For the remainder of the observations, various CNAs failed to reposition Resident #2 off her back or assist her to lie in bed.

During an interview on the afternoon of 07/18/12, an administrative nurse (#1) agreed staff should offer and encourage Resident #2 to lie down and reposition to reduce pressure on the right ischium.

- Review of Resident #4's medical record occurred on all days of survey. Diagnoses included generalized pain, osteoarthritis, dementia, and a current Stage 2 pressure ulcer to her coccyx. The quarterly MDS, dated 05/03/12, identified the resident required extensive assistance of two or more staff members for bed mobility and identified a Stage 2 pressure ulcer.

The current care plan, stated, "Problem: Potential for skin breakdown R/T osteoarthritis and fragile skin M/B [manifested by] stiff when moving and needs ext. [extensive] assistance with repositioning. Stage 2 to coccyx (R) [right] inner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CROSBY	705 SE 4TH ST CROSBY, ND 58730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 8 buttocks . . . Approaches: Reposition Q 2-3 HRS [hours] and PRN [as needed] . . ." Observation on 07/17/12 at 1:25 p.m. showed two CNAs (#5 and #6) assisted Resident #4 with toileting, transferred the resident to her bed, positioned her onto her left side, and placed a wedge cushion behind her back. At 5:00 p.m. Resident #4 remained on her left side (over 3.5 hours later). The facility failed to reposition Resident #4 every 2-3 hours as care planned.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and resident and staff interview, the facility failed to provide supervision and assistive devices necessary to prevent accidents for 2 of 3 sampled residents (Resident #1 and #9) transferred with a gait belt. Failure to use gait belts appropriately has the potential for residents to experience falls, injuries, and/or pain. Findings include: Review of the facility policy titled "Gait (Transfer)	F 323	F323: 1. Residents #1 and #9 will have their individual needs met by reviewing each resident's transfer lift assessment and the care plan will be updated to ensure the proper transfer is taking place. Also to ensure that the documented outcomes match the care plans and resident care sheet. 2. Residents that require assist of one or more staff members have the potential to be effect in this area. An MDS query will be generated to ensure all residents that require staff assistance with transfer will be reviewed to ensure their care plans are accurate. 3. An all staff meeting will be held prior to August 27, 2012 for all direct care givers on the proper use of gait belts in resident transfers. The physical therapist will provide a demonstration of proper transfer technique and appropriate gait belt use.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CROSBY	705 SE 4TH ST CROSBY, ND 58730

(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 Belt" occurred on 07/18/12. This policy, revised January 2009, stated, "Purpose: * To safely transfer or ambulate resident * To aid resident in maintaining balance * To avoid injury to both resident and staff member Note: Gait belts used unless medically contraindicated. Procedure . . . 2. Place belt around resident's waist over clothing . . . 4. Make sure belt is securely buckled so it does not slide. Belt should not be twisted and should be just snug enough so you can get your fingers under it. 5. When holding the belt an underhand grasp should be used. 6. Transfer or ambulate resident and remove belt . . ." - During the initial tour on the afternoon of 07/16/12, observation showed a bruise, approximately the size of a baseball and purple in color, on Resident #1's right inner forearm. The resident stated a staff member grabbed his arm and pulled to assist him to a standing position without using a gait belt, causing the bruise. Review of Resident #1's medical record occurred on all days of survey. Diagnoses included a left knee strain (after a fall on 02/08/12), gait and balance disturbance, osteoarthritis, and history of a cerebrovascular accident (CVA). The annual Minimum Data Set (MDS), dated 05/17/12, identified intact cognition and extensive assistance of two or more staff members for transfers.	F 323	4. An audit tool will be developed to monitor the proper transfer technique and proper use of the gait belt. The Physical Therapy Assistant or designee will be responsible for the completion of the audits. Audits will be completed on 5 random residents weekly x 1 month, monthly x 2 months. Results of the audits will be reported and discussed at the monthly QA meetings for further recommendations. 5. Completion date: August 27, 2012 See audit #3 for F 323	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CROSBY	705 SE 4TH ST CROSBY, ND 58730

(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		

The current care plan stated, "Problem: Alteration in mobility R/T [related to] osteoarthritis M/B [manifested by] needs W/C [wheelchair] for distances and walker in his room to transfer . . . Approaches: Transfers: extensive assistance of 1-2 depending on his day . . . has weakness to his right arm due to an old CVA . . . Ambulation: extensive asst. [assistance] of 1-2 with FWW [front-wheeled walker] in room . . . Problem: Potential for injury R/T weakness M/B past history of falling . . . Approaches: . . . Monitor for weakness and assist as needed . . ."

The CNA care card (a condensed care plan the CNAs carry) identified Resident #1 transferred with "assist of 1-2/gaitbelt/walker; w/c for ambulation."

Observation on 07/17/12 at 9:50 a.m. showed a CNA (#7) assisted Resident #1 to transfer from his wheelchair to his recliner by lifting up on the resident's belt attached to his pants. Observation showed the resident's knees buckled and he took small, shuffling steps. The CNA (#7) failed to utilize a gait belt when transferring Resident #1.

On 07/17/12 at 11:25 a.m., a CNA (#8) applied a gait belt around Resident #1's waist and transferred him from his recliner to his wheelchair, his wheelchair to the toilet, and the toilet to his wheelchair by lifting under the resident's arm with one hand and holding on to the gait belt with his other hand. During the observation, Resident #1's knees buckled, and his gait was unsteady. The resident stated his "left leg is dead - doesn't work" and identified he at times experienced pain in his right shoulder and left leg.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CROSBY	705 SE 4TH ST CROSBY, ND 58730

(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		

Observation on 07/17/12 at 1:50 p.m. showed a CNA (#8) applied a gait belt around Resident #1's waist and transferred him from his wheelchair to his recliner by lifting under the resident's left arm with one hand and holding on to the gait belt with the other hand.

The CNA (#8) failed to fully utilize the gait belt around Resident #1's waist and instead lifted under the resident's arm during the transfers.

During an interview on 07/18/12 at 12:05 p.m., an administrative nurse (#1) stated staff should transfer residents according to the CNA care cards. She confirmed the CNA care card identified Resident #1 is transferred with a gait belt.

Failure to use a gait belt appropriately resulted in a bruise to Resident #1 and may result in further pain and injury to Resident #1 and to all other residents in the facility who require a gait belt for transfers.

- Record review for Resident #9 occurred on 07/18/12. Medical diagnoses included rheumatoid arthritis, dementia with behaviors and a history of falls with a fracture to the left hip. The current MDS, dated 05/17/12, identified severe cognitive impairment, falls without injury since admission, and extensive assistance of two people for transfers.

The current care plan stated, "extensive assistance with bed mobility and transfers."

Observation on 07/18/12 at 1:55 p.m. identified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CROSBY	705 SE 4TH ST CROSBY, ND 58730

(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 two CNAs (#2 and #3) transferred Resident #9 from her wheelchair to her recliner. The CNAs placed a gaitbelt around Resident #9's waist, tightened it, and pivot transferred the resident into the recliner. Observation showed the CNA (#3) did not hold on to the gait belt, but instead, grabbed Resident #9 underneath her right arm and lifted upward during the transfer.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431	F431: 1. No residents were affected in this area. Refrigerator has been defrosted and cleaned. Staff will continue to monitor daily temperature checks. If the refrigerator is not able to meet the proper storage temperature the refrigerator will be replaced. 2. All residents receiving medications from that refrigerator have the potential to be affected in this area. These medications will be review and reordered as needed. 3. Education will be provided to the nurses on August 16, 2012. Nurses will be re-educated on the need to monitor refrigerator temperatures, to write the date opened on all vials of insulin and are should be discarded 28 days after opening. If not stored at the proper temperature, the medication needs to be destroyed including insulin, suppositories, and immunization solution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CROSBY	705 SE 4TH ST CROSBY, ND 58730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 13 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional literature, and staff interview, the facility failed to store all medications under proper temperature controls in 1 of 2 medication refrigerators (south medication room); and failed to discard outdated insulin vials in 1 of 2 medication refrigerators (north medication room). Failure to maintain the refrigerator within an acceptable temperature range and failure to discard insulin opened beyond the recommended time frame had the potential to affect the potency and efficacy of the medication. Findings include: Diabetes Care by the American Diabetes Association, Inc., January 2004, Vol. 27, Supplement 1, stated, ". . . Insulin Administration. . . Storage. . . Extreme temperatures ([less than] 35 [degrees Fahrenheit]) should be avoided to prevent loss of potency, clumping, frosting, or precipitation. Specific storage guidelines provided by the manufacturer should be followed. . . ." Diabetic Care, Volume 26, Number 9, September, 2003, pages 2666-2667, "How Long Should Insulin Be Used Once a Vial Is Started?" stated, ". . . The CPMP [Committee for Proprietary Medicinal Products] has proposed a	F 431	System Change: A new form for refrigerator temperature monitoring will be created for staff to document action taken to fix the problem if the temperature is out of range. All resident insulin vials will have the date opened and the expiration date written on a sticker and placed on the label of the vial or the box the insulin was provide in from the pharmacy. 4. An audit tool has been developed to monitor refrigerator temperatures. The Director of Nursing or designee will be responsible for the completion of the audits. Audits will be completed for the 2 refrigerators. One on each end of the facility. All refrigerators that store resident items will be monitored for proper temperature storage. Audits will be done weekly x 1 month, monthly x 2 months. The results of the audits will be reported and discussed at monthly QA meetings for any further recommendations. 5. Completion date: August 27, 2012. See audit #4 for F 431	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CROSBY	705 SE 4TH ST CROSBY, ND 58730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 14 maximum-use period of 28 days for sterile products . . . including insulin products. . . . Although an expiration date is stamped on each vial of insulin, a loss of potency may occur after the bottle has been in use for > 1 [more than 1] month . . . changes in insulin action can lead to significant changes in blood glucose control." Review of the Center of Disease Control (CDC) website: http://www.cdc.gov/vaccines/recs/storage/guide/vaccine-storage-handling.pdf, "Vaccine Storage and Handling Guide," dated December 2011, related to pneumococcal vaccines, stated, ". . . Unused portions of multidose vials should be refrigerated between 35°F and 46°F (2°C and 8° C). . . . Vaccine exposed to temperatures outside the recommended range - either too warm or too cold - requires immediate corrective action! . . ." Review of the facility policy titled "ACQUISITION, RECEIVING, DISPENSING AND STORAGE OF MEDICATIONS" occurred on 07/18/12. This policy, dated 2012, stated, ". . . Refrigerators holding medications (such as insulin, etc.) will be kept at 36-46 degrees F [Fahrenheit] . . . Check refrigerator temperatures daily . . ." - Observation of the North medication refrigerator on 07/18/12 at 4:00 p.m. , showed the refrigerator contained two insulin vials used beyond the maximum-use period dated 06/13/12 and 06/15/12. - Observation of the South medication refrigerator on 07/18/12 at 4:20 p.m., showed the temperature at 22 degrees F. Review of the refrigerator temperature log for July 01-18, 2012	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CROSBY	705 SE 4TH ST CROSBY, ND 58730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 15 identified the temperatures ranged between 28 and 32 degrees F. Medicaitons in the refrigerator included: * 1 opened vial of Humalog insulin * 1 opened vial of Lantus insulin * 1 unopened vial of Lantus insulin * 1 opened vial of pneumococcal vaccine * 1 opened vial of Mantoux (tuberculosis skin test medication) During an interview on 07/18/12 at 4:50 p.m., an administrative nurse (#1) stated she would expect the medication refrigerators maintained between 36 and 46 degrees F and insulin not administered beyond 28 days of opening the vial.	F 431		