North Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8091	A. BUILDING _____ B. WING _____	12/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKE COUNTR	1332 10TH ST NE DEVILS LAKE, ND 58301

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B 000	INITIAL COMMENTS For the unannounced licensure survey, started on 12/28/15 and completed on 12/30/15, the sample included 4 residents for complete review and 1 closed record for review. In addition, the sample included 1 supplemental resident to verify specific concerns during the survey. Tier II citations included B1020, B1040, B1240, B1540, and B1800.	B 000		
B1020	33-03-24.1-10,2 FIRE SAFETY 2. Fire drills must be held monthly with a minimum of twelve per year, alternating with all workshifts. Residents and staff, as a group, shall either evacuate the building or relocate to an assembly point identified in the fire evacuation plan. At least once a year, a fire drill must be conducted during which all staff and residents evacuate the building. This state licensing rule is not met as evidenced by: Based on review of facility fire drill records, policy review, and staff interview, the facility failed to conduct monthly fire drills which included alternating on all work shifts, activation of the fire alarm system, and/or relocation to an assembly point identified in the fire evacuation plan for 9 of 12 months reviewed (December 2014, January, February, March, April, May, July, August, and November 2015). Failure to involve residents during nighttime drills, conducting "silent drills," and failure to ensure residents relocate to a safe area does not allow the facility to determine the residents' actual response to the fire alarm and may result in inaccurate evacuation scores.	B1020	B-1020 The corrective actions taken to assist residents affected by this practice will be as follows: 1. A fire drill annual calendar will be set up monthly so that each shift is covered on at least a quarterly basis. 2. Each fire drill will include documentation that the drill included both residents and staff. This will include night drills as well. Residents and staff will be required to participate in drills when available during the drills. 3. Drills will be alarmed. Silent alarms will not be currently conducted. 4. All staff and residents will be instructed to evacuate to a certain	2/13/16

Health Resources Section

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan E Pogeeand — TITLE: Administrator — (X6) DATE: 1/20/16

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B1020	Continued From page 1 Findings include: Review of the facility policy titled "Fire Drills" occurred on 12/29/15. This policy, revised June 2014, stated, "Purpose: To provide practice for residents and staff in the event of a fire in the senior living community (SLC). . . . Procedure: . . . In assisted living communities, regular fire drills are often mandated by state regulations . . . While these drills may cause some increased anxiety for residents, the benefits of an organized and practiced response to a fire are an essential part of offering the most reasonable protection to the staff and residents . . . Assisted Living Communities Fire Drills: Fire exit drills shall include the transmission of a fire alarm signal and the simulation of fire conditions, . . . Drills shall be conducted per state regulations . . . at least quarterly on each shift . . ." Review of the facility's monthly fire drill records occurred on 12/29/15. The records identified: * Drills on the night shift excluded resident involvement and were conducted for staff education only (02/27/15, 05/29/15, 08/28/15, and 11/13/15). * Staff conducted five of 12 monthly drills (01/30/15, 02/27/15, 05/29/15, 08/28/15, and 11/13/15) as "silent drills," without activation of the alarm at the time of the drill. * Staff failed to ensure resident relocation to an assembly point identified in the fire evacuation plan for nine of the 12 monthly drills (12/31/14, 01/30/15, 02/27/15, 03/23/15, 04/29/15, 05/29/15, 07/29/15, 08/28/15, and 11/13/15). During an interview on 12/29/15 at 5:00 p.m., a maintenance manager (#2) stated, "So we don't disturb the residents, we sound the alarm during	B1020	safe area identified in the fire plan for each drill. 5. At least once a year, a complete evacuation to the outside will be done. All residents were identified to have the potential to be affected. The current policy regarding fire drills will be reviewed with all staff. Staff and residents were instructed that fire drills will not currently be silent alarms. Staff and residents will be informed that fire drills are done monthly and on each shift at least quarterly and that all staff and residents will need to evacuate to a safe area identified in the fire plan during the drill. The Senior Living Manager will audit fire drills on a quarterly basis for the first year and make changes as needed. The audit will then be presented to the Quality Assurance Committee for review to assure continued compliance for the first year on a quarterly basis and then as needed thereafter.	

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B1020	Continued From page 2 the day, and that night or a night later in the month, we educate the nighttime staff" on the fire drill process.	B1020		
B1040	33-03-24.1-10,4 FIRE SAFETY 4. Written records of fire drills must be maintained. These records must include dates, times, duration, names of staff and residents participating and those absent and why, and a brief description of the drill including the escape path used and evidence of simulation of a call to the fire department. This state licensing rule is not met as evidenced by: Based on review of facility fire drill records, policy review, and staff interview, the facility failed to maintain a complete written record of the fire drills conducted for 9 of 12 months (December 2014, January, February, March, April, May, July, August, and November 2015) reviewed. Failure to include the time of the drill; the names of residents participating or if not participating, the reason why; the location of the fire; and the escape path used does not allow the facility to assess and monitor the effectiveness of the drills and make changes as necessary. Findings include: Review of the facility policy titled "Fire Drills" occurred on 12/29/15. This policy, revised June 2014, stated, ". . . Policy: When required by state or local law, SLCs [senior living communities] will conduct fire drills in accordance with the governing regulations of the community. . . . Assisted Living Communities Fire Drills: . . .	B1040	B-1040 The corrective actions taken to assist resident affected by this practice will be as follows: 1. Written records of fire drills will be maintained and will include the following information-date, time, duration, name of staff and residents participating and those absence and why, and a brief description of the drill including the fire location and the escape path used to the safe area. 2. The records will also include evidence that the fire department received the fire call. All residents were identified to have the potential to be affected. The current policy regarding fire drills will be reviewed with all staff. Staff will be	2/13/16

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B1040	Continued From page 3 Documentation shall include the date and time of the drill. Refer to the Risk Management Manual, Fire Drills/Reports." Review of the facility's monthly fire drill records occurred on 12/29/15. The records identified staff failed to document the following: * The time for one drill (11/13/15). * A valid reason why (such as a resident in the hospital) each resident failed to participate for eight drills (01/30/15, 02/27/15, 03/23/15, 04/29/15, 05/29/15, 07/29/15, 08/28/15, and 11/13/15). * The location of the fire for three drills (01/30/15, 02/27/15, and 11/13/15). * The escape path used on two real fire alarms (02/04/15 and 11/16/15). The facility form lacked an area to address the escape path residents used, however on three of the 12 fire drills, staff documented the relocation area (06/29/15, 09/30/15, and 10/28/15). During an interview on 12/29/15 at 5:00 p.m., a maintenance manager (#2) stated staff do not record escape paths and there may not be a fire location if the drill occurred with alarm testing.	B1040	instructed on how to properly fill out the fire drill report and what to include. The Senior Living Manager will audit fire drills on a quarterly basis for the first year and make changes if needed. During the audit she will check to assure the report includes date, time, duration, name of staff and residents participating and those absence and why, and a brief description of the drill including fire location and the escape plan used to the safe area. The audit will then be presented to the Quality Assurance Committee for review to assure continued compliance on a quarterly basis for the first year and then as needed thereafter.	
B1240	33-03-24.1-12,4 RESIDENT ASSESSMENTS/CARE PLANS 4. The care plan must be updated as needed, but no less than quarterly. This state licensing rule is not met as evidenced by: Based on observation, record review, and policy review, the facility failed to update the care plan for 1 of 4 sampled residents (Resident #2). Failure to update the care plan limits staff	~~B1240~~		

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B1240	Continued From page 4 understanding of residents' needs and does not allow for continuity of care. Findings include: Review of the facility policy titled "Resident Service Plan" occurred on 12/30/15. This policy, revised June 2014, stated, ". . . 7. the Resident Service Plan will be updated according to changes in the resident assessment and at least annually or per state regulations [quarterly]. . . ." On 12/28/15 at 4:25 p.m., observation showed Resident #2 wore a mask connected to a Bipap [bilevel positive airway pressure] machine while napping in her room. Review of Resident #2's medical record occurred on December 29-30, 2015. Diagnoses included atrial fibrillation (cardiac arrhythmia) and obstructive sleep apnea. A physician order, dated 08/25/15, stated, "Continue Bipap for sleep apnea (severe)." A nurse's note, dated 08/10/15, stated, "Sent up medtronic home monitor system for pacer check and monitor is not working. Called cardiologist [name] office . . . requested . . . a working number for medtronic to order another home monitor. . . ." A clinic visit on 10/05/15 for a pacemaker check indicated "normal device function" and included an order, "In-clinic visit 6 months." Resident #2's current Resident Service Plan/Care Plan stated for Sleep Habits: "Sleep through Night . . . Goals/Strengths: Will maintain good sleep habits" The care plan included "Diagnosis: . . . Cardiac Defibrilator placed 2/2013 [February 2013]" Staff failed to include the diagnosis of obstructive sleep apnea, or address problems	B1240	B-1240 Resident #2's care plan was updated to include the diagnosis of sleep apnea, to encourage use of bipap machine as well as to perform pacemaker checks according to doctor's orders. A review will be made of all resident's care plans to assure that necessary diagnosis are on the care plan as well as devices that are needed to assist the resident or that are needed to be checked. Staff involved in care planning were asked to review the current policy for understanding the need to update the care plan at least quarterly and as needed when changes occur. At least 2 residents will be reviewed and audited each quarter for the first year to assure that their care plan is updated and is relevant to the care of the resident. To assure continued compliance, the audit will then be presented to the Quality Assurance Committee for review on a quarterly basis for the first year and then as needed after that.	2/13/16

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B1240	Continued From page 5 and interventions related to the resident's sleep apnea requiring the Bipap and a cardiac pacemaker requiring routine checks to ensure correct functioning.	B1240		
B1540	33-03-24.1-15,4 PHARMACY/MED ADM SERVICES 4. All medications used by residents which are administered or supervised by staff must be: a. Properly recorded by staff at the time of administration. b. Kept and stored in original containers labeled consistently with state laws. c. Properly administered. This state licensing rule is not met as evidenced by: Based on observation, record review, review of manufacturer's instructions, and staff interview, the facility staff failed to properly administer medication to 1 of 1 resident (Resident #2) with insulin-dependent diabetes. Failure to correctly prime an insulin pen (mechanical device for storing and administering insulin) by performing an airshot has the potential for the resident to receive an inaccurate amount of insulin. Findings include: NovoLog FlexPen manufacturer's instructions, dated 2015, stated, ". . . Step 2: Doing the airshot before each injection: Small amounts of air may collect in the cartridge during normal use. To	B1540	B-1540 The corrective actions taken to assist residents affected by this practice was as follows: 1. All staff administering medication to Resident #2 were instructed on the proper administration of the NovoLog FlexPen. 2. A new written procedure was added to our policies and procedures regarding the proper administration of the NovoLog FlexPen. 3. Staff were reminded of the 5 rights of medication administration. No other resident was identified to have the NovoLog FlexPen but staff were reminded of the 5 rights of medication administration for all residents.	2/13/16

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B1540	Continued From page 6 avoid injecting air and ensure proper dosing: * Turn the dose selector to 2 units * Hold your FlexPen with the needle pointing up, and tap the cartridge gently a few times, which moves the air bubbles to the top * Press the push-button all the way in until the dose selector is back to 0. A drop of insulin should appear at the tip of the needle * If no drop appears, change the needle and repeat. If you still do not see a drop of insulin after 6 tries, do not use the FlexPen . . ." On 12/28/15 at 5:20 p.m., observation showed a medication aide (MA) (#3) prepared Resident #2's NovoLog insulin pen for administration. The MA turned the dose selector to two units, pointed the pen downward over the garbage can, and pressed the button until the dose selector reached zero. The MA failed to point the pen upward and tap the cartridge before performing the airshot. During an interview on 12/29/15 at 5:55 p.m., a licensed nurse manager (#1) stated she trained the medication aides to prime insulin FlexPens by selecting two units and ejecting the insulin with the pen pointed upward. She added the facility has no policy on insulin pens, but follows the manufacturer's instructions.	B1540	To correct the deficiency, education was provided to all staff members. A new procedure was added to our policy and procedure manual that specifically addressed this insulin pen. The Senior Living Manager will do an audit on at least 2 staff members on a quarterly basis for the first year to assure medications are properly administered and to make changes if needed. These audits will be then be presented to the Quality Assurance Committee to assure continued compliance on a quarterly basis for the first year and then as needed. We will audit monthly for the first quarter. T.C with Adm 2/1/16 dl.	
B1800	33-03-24.1-18 DIETARY SERVICES 33-03-24.1-18. Dietary services. The facility must meet the dietary needs of the residents and provide dietary services in conformance with the North Dakota sanitary requirements for food establishments. Dietary services must include:	~~B1800~~		

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B1800	Continued From page 7 This state licensing rule is not met as evidenced by: Based on observation, policy review, and staff interview, the facility failed to provide dietary services in conformance with the North Dakota sanitary requirements for food establishments in 2 of 2 food service areas (kitchen and dining room). Failure to ensure staff consistently follow a recommended procedure for washing and sanitation of food/nonfood contact surfaces, ensure proper concentration of sanitizing solutions, and dispose of expired food/fluid increased the risk of foodborne illnesses for all the residents. Findings include: North Dakota Requirements for Food and Beverage Establishments, approved 04/01/12, require in part the following: * 33-33-04-51. Wiping cloths and working containers - Use limitation. ". . . 3. Cloths used for cleaning nonfood-contact surfaces of equipment, such as counters, dining tabletops, and shelves, must be clean and rinsed as specified in subsection 2 [2. Cloths used for wiping food spills on kitchenware and food-contact surfaces of equipment must be clean and rinsed frequently in one of the sanitizing solutions permitted in section 33-33-04-52 and used for no other purpose. These cloths must be stored in the sanitizing solution between uses.] . . ." Review of the facility policy titled "Cleaning - Sanitation of Non-Food Contact Surfaces occurred on 12/29/15. This policy, dated February 2013, stated, ". . . Policy: The center will store, prepare, distribute and serve food under sanitary conditions at all times. Procedure: 1. Cleaning	B1800	B-1800 The corrective actions taken to assist residents affected by this practice will be as follows: 1. The automatic dispenser for 146 Multiquat sanitizer will be checked on a daily basis when the bucket is filled and this will be recorded on a log. 2. Two buckets will be used to wash the dining room tables. The first bucket will contain soap and water to cleanse the tables. The second bucket will contain the Multiquat Sanitizer and will be used after the soap and water to assure the tables are clean 3. The prune juice was thrown. All residents were identified to be potentially affected by this. Education was provided to the kitchen staff on how to check the sanitizer. A log was developed to record this. The current policy was reviewed with staff and education was provided to all staff regarding the need to use a two step process when washing tables that includes	2/13/16 T.C. with Alan 2/11/16 dp

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B1800	Continued From page 8 and sanitizing surfaces is a two-step process. Surfaces first must be cleaned and rinsed before being sanitized. . . . 3. Sanitizing solutions must be checked with test strips for proper solution strength. . . . 14. Cabinets, drawers and counter tops: a. Clean and sanitize between uses . . . 16. Dining room tables: a. Cleaned and sanitized before the breakfast meal and after each meal service." Review of the facility policy titled "Food Storage" occurred on 12/29/15. This policy, revised December 2013, stated, ". . . Procedure: . . . 5. Expiration dates will be checked on a regular basis and foods/fluids that have expired will be discarded. . . ." - On 12/28/15 at 12:39 p.m., observation of the kitchen showed an automatic dispenser for 146 Multiquat sanitizer and a red bucket of clear liquid on the counter. A dietary staff member (#4) stated the red bucket contained sanitizing solution (quat) from the automatic dispenser which he filled about an hour ago. He stated he prepares a new bucket before each meal. When asked to check the concentration level of the quat solution in bucket, the staff member (#4) stated, "I've never tested that solution." With cuing, the staff member checked the solution and obtained an acceptable reading. He stated the facility kept no log for the quat bucket. - On 12/28/15 following lunch, observation showed a Universal Worker (#5) used a cloth stored in the red bucket to wipe the surface of the dining room tables after residents finished eating lunch. Observation failed to show a second bucket with soap and water to cleanse the tables first.	B1800	the first step being to wash the tables with soap and water and the second step to use the sanitizer. Looking for expired items was added to a checklist that is done daily for the kitchen staff. To assure continued compliance and audit tool will be developed and used by the Senior Living Manager on a quarterly basis to check whether staff are checking the sanitizer, properly washing tables and checking for expired items in the dietary area. This audit will then be presented to the Quality Assurance Committee to monitor compliance on a quarterly basis for the first year and then as needed thereafter. We will audit monthly for the first quarter. T.C. with Adm 2/1/16 dl.	

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B1800	Continued From page 9 - On 12/29/15 at 9:00 a.m., observation showed a Universal Worker (#5) used a cloth stored in the red bucket to wipe off a dining room table after the last resident finished breakfast. The worker stated she does not wash the tables off before wiping with the cloth in the sanitizing solution. - On 12/29/15 at 8:45 a.m., observation of the dietary dry storage room identified a 96-count case of four-ounce prune juice containers, with 68 containers remaining. The case and each individual container was labeled with a "use by: 06/04/15" date, nearly seven months prior. A dietary staff member (#4) stated, "I will get rid of it. We don't use much prune juice."	B1800		