STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 February 19, 2013 and completed on February 21, 2013, the sample included two (2) residents for complete review, eight (8) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000	**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.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, policy and procedure review, and staff interview, the facility failed to assess resident behaviors for causative/precipitating factors, develop and implement specific and individualized interventions, monitor the effectiveness of these interventions, and revise them accordingly for 2 of 8 sampled residents (Resident #4 and #5) identified by the facility as exhibiting resident-to-resident physical behaviors. Failure to assess behaviors, implement interventions, and monitor resident response to interventions resulted in an increase in Resident #4's antipsychotic medication dosage and also increases the potential for residents to harm each other.	F 250	F-250 1. Resident #4's care plan was updated to reflect identification of other residents involved using assigned Medical Record Numbers. Resident #4's IDP (Interdisciplinary Progress) notes will reflect the identification of other residents involved using assigned Medical Record Numbers if behaviors occur. Resident #4's dosage of antipsychotic medication was reviewed 2-28-13. Physician noted "mood and affect appear more stable at this dose" and no changes were made.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3-27-13

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
	355104	A. BUILDING _____ B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 250	Continued From page 1 Findings include: Review of the facility policy titled "Behavior Management Committee" occurred on the afternoon of 02/21/13. This policy, dated September 2010, stated, "A Behavior Management Committee is formed to analyze the root cause(s) of a resident's behavior as well as provide alternatives to staff for solutions. It is designed as an interdisciplinary vehicle using the talents of staff across all shifts and disciplines . . . focuses on the identified treatment and evaluation of behaviors . . . Information and plans generated from this meeting will be used to update care plans on these residents on a more frequent basis than the traditional quarterly care plan. . . . The social worker is considered to be the lead person in developing and promoting the concept of this committee and coordinating its actions. . . Mood and behavior symptoms as well as causes, interventions and outcomes are documented in the Mood/Behavior module. . . . Starting the approach with the target behavior . . . can be helpful to pinpoint the type of intervention that staff should use for a specific mood or behavior symptom . . ." - Review of Resident #5's medical record occurred on February 20-21, 2013. Diagnoses included dementia with psychotic features and anoxic (absence of oxygen) brain injury. Resident #5's most recent Minimum Data Set (MDS), dated 12/30/12, identified severely impaired cognition. Review of the interdisciplinary progress notes (IDPs) from June 2012 - February 21, 2013, identified Resident #5 exhibited the following	F 250	Resident #5's care plan was updated to reflect identification of other residents involved using assigned Medical Record Numbers and specific interventions. Resident #5's IDP (Interdisciplinary Progress) notes will reflect the identification of other residents involved using assigned Medical Record Numbers if behaviors occur. 2. A list of residents with behaviors that have the potential to be affected in this area will be identified through an MDS query of Section E and the Behavior Management Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 250	Continued From page 2 behaviors: *06/17/12 at 3:00 p.m. - "Out in commons area - has pulled slacks down to her knees x 2 - asked why she was doing that et [and] she responded that someone told her to - was then sitting in chair holding male res's [resident's] hand et he leaned over et kissed her - res removed from area." *09/29/12 at 10:00 a.m. - "Res came out to common's area and sat down on male resident's lap - putting arms around his neck - was immediately removed - talked [with] res about inappropriate behavior." *10/22/12 at 4:00 p.m. - "This author saw resident entering 108A's [Resident #4's] room [with] him, and enc [encouraged] her not to visit in other's rooms. She readily took this writer's hand and walked to common's area and found her a magazine to look [at]." *10/28/12 at 3:45 p.m. - "Res has been found in other res's beds today. Resident is easily redirected." *11/18/12 at 3:30 p.m. - "Resident was observed by another res. being lead by the hand into an empty room, a family suite. [Facility] policy followed per protocol." *01/25/13 at 9:00 p.m. - "Res found laying [sic] on bed in another res['s] room." The interdisciplinary progress notes lacked consistent identification of the other residents involved in the above notes, which does not allow the facility to adequately track and trend behaviors which affect other residents and to prevent/minimize resident to resident behaviors. Review of an abuse investigation report, dated 11/18/12 at 3:30 p.m., identified [Resident #2] reported that [Resident #5] lead [Resident #4] by	F 250	3. A mandatory All Staff personnel inservice on 4-2-13 will address the policy and procedure for the "Behavior Management Committee" with an emphasis on all disciplines documenting behaviors properly and identifying specific residents involved in behaviors for the Committee. The Committee will meet monthly to analyze the root cause of a resident's behaviors as well as provide alternatives/interventions to staff. Documentation will assist the Committee with tracking, trending, implementing interventions and monitoring the effectiveness of the interventions. Care plans will be updated as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 250	Continued From page 3 the hand into [Resident #2's] room. When [Resident #2] asked what they were doing in his room, [Resident #4] immediately turned and led [Resident #5] by the hand . . . into [another room]. [Resident #4] closed the door. [Resident #2] hollared [sic] what are you doing in there with her? [Resident #4] yelled at [Resident #2] to mind his own business. [Resident #2] stated "that man should not be leading the girl around like that because she does not know any better." 15 minute checks of [Resident #4] initiated and a body assessment of [Resident #5] with no apparent harm. When [Resident #4] was questioned regarding [Resident #4's] actions towards her, [Resident #5] said "he touched me with his mouth." When asked if he touched her anywhere else. [Resident #5] replied "no". When stressed to [Resident #5] that is was very important to tell us if [Resident #4] had touched her anywhere else. When asked if he had touched her in the bra and panty area. Then [Resident #5] pointed to those areas and said "yes." Review of Resident #5's incident reports, identified the following: *12/12/12 at 12:05 p.m. - "This resident was attempting to hold a male Resident's [Resident #4] hand, she only had hold of two fingers et. pinched male Res fingers et. wouldn't let go. The male resident admits "he dug his fingernail into [Resident #5's] R [right] middle finger" - broke skin. Male Res had no visible injury to his L [left] hand." *02/10/13 at 7:30 p.m. - "CNA [certified nursing assistant] entered rm [room] . . . [Resident #4's room] and found res [with] male res. Male res was holding her hand and had his tongue in her R	F 250	4. An audit will be developed to monitor the documentation of care plans and IDP notes of residents identified through the MDS Query and the Behavior Management Committee. The audit will be completed weekly times 4 weeks and monthly times 2 months. The results of the audits will be reported to the QA/CQI committee for future recommendations. The audit will be completed by the Social Worker or her designee 5. April 3, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 250	Continued From page 4 [right] ear. Res was taken from rm to common's area." Resident #5's Interdisciplinary Assessments and Summary Reviews stated: *10/05/12 -"SS [social services] quarterly note . . . [Resident #5] wanders daily et will go into other resident rooms and staff offices. . . ." *12/31/12 - "Nrsg [nursing]/Rehab [rehabilitation] quarterly note . . . Did have incident [with] another resident [with] [no] adverse effects - refer to [facility report], dated 11/18/12." *01/04/13 - "SS quarterly note . . . [Resident #5] wanders daily et. does go into other resident's rooms. . . ." Review of Resident #5's "Mood and Behavior Reports" from March 7, 2012 to February 21, 2013 identified behaviors of wandering and other behaviors not directed towards others in March 2012. No behaviors, including physical resident-to-resident behaviors, were identified from April 2012 - February 21, 2013. Resident #5's current care plan identified the problem of "Alteration in thought process R/T [related to] dementia and anxiety m/b [manifested by] forgetful and periods of confusion." Plans and Approaches included: "Decision making is poor. Needs reminders, supervision, and cues in planning and organizing, alarms used due to poor safety awareness, tag alarm used due to elopement risks." The care plan lacked interventions for Resident #5's behaviors with Resident #4 and her wandering into other residents' rooms and beds. During an interview on the afternoon of 02/21/13,	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 250	Continued From page 5 an administrative social services staff member (#6) was unable to provide further information. - Review of Resident # 4's medical record occurred on February 19-21, 2013. Diagnoses included vascular dementia, anxiety, and history of visual hallucinations and paranoia. Resident #4's most recent MDS, dated 01/02/13, identified intact cognition. Resident #4's interdisciplinary progress notes from June 2013 to present identified the resident exhibited the following behaviors: *06/17/12 at 2:00 p.m. - "Sitting in commons area holding hands [with] female resident - leaned over et [and] kissed her x 2 [two times] - took res [resident' into nurses office et spoke [with] him - at first denied it but then did admit it - told res it is inappropriate - ? [question] comprehension." *06/26/12 at 3:00 p.m. - "Watched res following female resident to her room . . . earlier a staff member reported she saw another female resident just getting up from his lap out in commons area." *07/25/12 at 1:00 p.m. - ". . . Resident talks frequently about getting married and 'needing a woman'. . ." *09/03/12 at 4:00 p.m. - "Resident reminded many times today that he is not to be hand holding or kissing [with] a female resident - had caught him kissing her earlier in day - will not stay away from her for more than a few minutes . . ." *09/30/12 at 4:30 p.m. - "overheard res walking up to female resident and telling her 'come to my room' - talked [with] him about his behavior but just walked away from me." *10/02/12 at 8:20 p.m. - "Res was redirected from female resident again tonite. Was seen kissing	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 250	Continued From page 6 female resident by other female residents. These lady residents then reported to me. Writer told res he is not to touch the female resident. He told writer, 'why can't I, others do.' Unsure what he meant by others." *10/22/12 at 4:00 p.m. - "This author saw resident encouraging female [room number] to come into his room. When this reporter reminded him that [room number] could not be alone [with] him in his rm [room], just shrugged his shoulders and closed the door. . . ." *11/07/12 at 9:30 p.m. - Writer witnessed res kissing fellow female res. Spoke [with] res et asked that he not kiss this res, explained female res is married et her family would be upset. Res agreed he would not kiss female res again. Stated, 'she asks everybody to hold her hand.' Informed res he could hold her hand if she requests, but [no] kissing." *11/18/12 at 3:15 p.m. - Res was observed by another res, leading a female resident into Room [number] vacant at this time. Policy followed per GSS [Good Samaritan Society] protocol." *11/22/12 at 10:00 p.m. - ". . . female res noted to approach res a [number] of times. Res stated 'I can't talk to you' [and] walked away. Has visited [with] other fellow res. . . ." *11/24/12 at 8:00 p.m. - Continue to monitor res. . . .Writer made res aware he was being observed and that he needs to follow the limits set for him." *11/27/12 at 4:00 p.m. - "[Name of Physician] had suggested looking at a more appropriate placement for [Resident #4] in a special care unit. Writer contacted several local facilities to [check] on openings. . . . said they wouldn't admit someone without a definite payment source. . . " *12/13/12 at 9:00 p.m. - Res was seen by CNA to kiss a lady resident in common area. CNA told	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 250	Continued From page 7 him 'You know your not to do this and is inappropriate.' His response was 'I was just kissing her good nite'. . ." *12/18/12 at 10:00 p.m. Res spent his evening visiting [with] a lady resident whose family is okay [with] him interacting [with] her. . . ." *01/01/13 at 10:15 p.m. - "res sat down on couch beside female resident and began holding her hand. became very angry when reminded he is not to sit beside this resident. Was asked to move 3 x [three times] before he stood up and left." *01/11/13 at 10:30 a.m. - "Holding hands [with] female resident from [room number]. Reminded to respect each other's space - 'she likes holding hands.' Enc [encouraged] not to do so. . . ." *01/26/13 at 9:00 a.m. - "Reminded of importance not to seek out [room number]. 'I'm sorry, I forgot'. . ." *02/10/13 at 7:30 p.m. - "Res rm [room] mate called CNA to rm, rm mate sitting in hallway, door closed - rm mate stated 'the blonde lady is in my room.' Upon opening door found res holding female res hand [and] had his tongue in her R [right] ear. Female res removed from area. Writer spoke to res [and] sternly reminded him behavior was unacceptable." *02/10/13 at 10:00 p.m. - "Female res has approached res x 2 during eve [evening] redirected by staff. Res has been monitored closely." *02/11/12 at 1:20 p.m. - [Name of Physician] informed of incident 2/10/13. D.O. [Doctor Order] to [increase] Seroquel (antipsychotic medication) . . ." *02/19/13 at 8:00 p.m. - CMA [Certified Medication Aide] reported res was [with] female res in empty rm. Female res removed from rm et	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 250	Continued From page 8 res informed this behavior is unacceptable. . . ." Resident #4's Interdisciplinary Assessments and Summary Reviews identified the following: *07/05/12 Social Services - ". . . He may follow certain female residents into their room. Staff redirect him by saying it's better to visit in commons area. . . ." *10/08/12 Social Services - ". . . He seeks out certain female residents. Staff remind him not to enter their rooms. Staff separate the residents if he tries to hold hands or kiss. . . ." *10/08/12 Activities - ". . . There are several female residents he visits [with] during the day at times needs reminding they are married or not to go into their rooms, diversional activities offered. . . ." *10/10/12 Care Plan Note - ". . . Behaviors were reviewed et updated on care plan. Will cont [continue] to monitor [and] intervene PRN with this behaviors." 01/08/13 Social Services - ". . . He continues to seek out certain female residents. Staff monitor and intervene PRN." 01/09/13 Care Plan Note - ". . . Staff continue to monitor [and] intervene PRN as he seeks out certain female residents." The interdisciplinary progress notes lacked consistent identification of the other residents involved in the above notes, which does not allow the facility to adequately track and trend behaviors which affect other residents and to prevent/minimize resident to resident behaviors. Review of Resident #4's "Mood and Behavior Report" from April 2012 - February 21, 2013 identified no behaviors, including physical	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 250	Continued From page 9 resident-to-resident behaviors during this time period. Resident #4's current care plan identified the problem of "Alteration in thought process rt dementia . . . forgetfulness and may follow certain female residents into their rooms. 2/01/13 May try to hold hands with certain female residents." Plans and Approaches included ". . . Redirect out of female's rooms by saying its better to visit in commons area . . . May try to hold hands or kiss certain female residents. Intervene and separate PRN. If holding hands, redirect resident from the area." The care plan failed to identify the "certain female residents" that Resident #4 tries to hold hands with or kiss. During interview on the morning of 02/21/13, an administrative staff member (#2) stated Resident #4 is friends with two female residents. The staff member (#2) stated one of the female residents thinks Resident #4 looks like her husband and likes to sit by him and talk with him. The staff member stated she has talked with the family of the female resident regarding this relationship and they are accepting of this friendship. The staff member stated the other female resident (Resident #5) seeks out Resident #4 and likes to hold hands with him. The staff member confirmed staff had not documented Resident #4's behaviors in the Mood and Behavior Report.	F 250		
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	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 10 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 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, staff interview, and facility policy review, the facility failed to ensure three vials of Ativan were accounted for in 1 of 1 medication room. Findings include: Review of the facility policy and procedure, "Controlled substances," occurred on 02/21/13. This document, revised March 2011, stated, "PURPOSE, To provide verification and correct count of controlled substances on hand . . . PROCEDURE: 1. One nurse unlocks the controlled substances storage unit and counts controlled drugs, per state regulations, on hand for each resident. 2. The other nurse assists by watching and verifying the count in the individual resident's	F 425	F-425 1. On 03-26-13 our facility Medical Director reviewed the E-kit medication list and injectable Ativan has been added to the list. A count was started and will continue according to the "Controlled Substances" Policy and Procedure. Ativan vials were placed in a lockbox to be stored in the medication room refrigerator. 2. All residents in the facility that may require injectable Ativan have the potential to be affected in this area. 3. A mandatory licensed and certified personnel inservice on 4-2-13 will address the policy and procedure "Controlled Substances" with an emphasis on proper documentation for E-kit medications.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 11 Medication Administration Record (GSS #245) or Documentation Record (GSS #267C) or Controlled Substance Record . . . 5. Add additional medications delivered. Initial if count is correct and verified . . . 9.1 CONTROLLED MEDICATION SCHEDULES . . . Substances classified as Schedule IV controlled Substances are those with: a low potential for abuse . . . and abuse potential which may lead to limited physical dependence or psychological dependence . . . lorazepam (Ativan)." Observation, on 2/20/13 at 5:00 p.m., of the medication room revealed three vials of Ativan in a small plastic case stored in an unlocked medication refrigerator. The emergency kit (E-Kit) list of medications did not include a count of the three vials of Ativan in the refrigerator. During an interview on 02/21/13 at 12:30 p.m., an administrative nursing staff member (#2) revealed she was not aware the Ativan was not being counted. She verified Ativan was a controlled drug and should have been accounted for. She stated the Ativan vials are considered part of the E-Kit, and should have been on the E-Kit's medication list.	F 425	4. An audit will be developed to monitor the count of injectable Ativan. The audit will be completed weekly times 4 weeks and monthly times 2 months. The results of the audits will be reported to the QA/CQI committee for future recommendations. The audit will be completed by the DNS or her designee 5. April 3, 2013.	
F 494 SS=D	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program	F 494		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 494	Continued From page 12 approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter. This REQUIREMENT is not met as evidenced by: Based on review of the state nurse aide registry files, facility policy review, facility record review, and staff interview, the facility failed to ensure 1 of 5 nursing assistants (Individual A) working with residents in the facility remained certified and one nursing assistant (Individual B) who had worked within the facility remained certified. Individual A provided 448 hours and Individual B provided 238.5 hours of nursing related services without verifying competency through certification. Failure to ensure certification of caregivers has the potential to affect resident care. Findings include: Review of the facility policy and procedure, "Registry/Licensure Verification," occurred on	F 494	F-494 1. DNS contacted state regarding licensure of CNA "A" and status is active as of 2-21-13. Facility contacted CNA "B" regarding licensure and CNA "B" decided not to re-certify and employment was terminated 01-31-13. The spreadsheet currently in use to monitor expiration dates and notifying staff of upcoming renewal licensure/certification dates has been updated and had been reviewed quarterly. 2. All residents in the facility have the potential to be affected in this area.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 494	Continued From page 13 02/21/13. This document, revised January 2010, stated, "PURPOSE, To establish policy and procedure regarding employee certifications, licenses and other credentials. To ensure compliance with applicable laws and regulations. Current employees: 1. It is the employee's responsibility to renew all documents as required and to provide his/her immediate supervisor with renewals and updates as they occur. a. If licenses are past due, the employee will not be allowed to work and placed on General Leave of Absence. Appropriate corrective action may take place. b. A copy of the renewed license, registration, certification and/or other credentials will be placed in the employee's permanent personnel file." - Review of employee files on 02/21/13 at 10:30 a.m. with an administrative staff member (#3) revealed Individual A's certification expired on 11/18/12. This nursing assistant worked with residents in the facility without certification for a total of 448 hours between 11/19/12 and 02/21/13. During an interview on the morning of 02/21/13, an administrative staff member (#2) verified Individual A's certification was expired and the facility's process failed to identify the expired certification. - On 01/02/13, Individual B contacted the nurse aide registry personnel regarding recertification. The nurse aide registry personnel noted Individual B's certification expired on 03/19/12. Information was requested from the facility regarding the dates and hours Individual B worked.	F 494	3. A mandatory certified and licensed personnel inservice on 4-2-13 will address the policy and procedure "Registry/Licensure Verification" and highlight the employee's responsibility to provide his/her immediate supervisor with renewals and updates as they occur. The spreadsheet with expiration dates of all licensed and certified staff will be updated and reviewed monthly and upon orientation of new employees to monitor expiration dates in order to notify staff of upcoming renewal dates for licensure/certification.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 494	Continued From page 14 On 01/03/13, an administrative staff member (#3) provided information to the nurse aide registry personnel. The information identified Individual B worked with residents in the facility, without certification, for a total of 238.5 hours between 03/19/12 and 08/04/12.	F 494	4. An audit will be developed to monitor the monthly spreadsheet of all licensed/certified personnel. The audit will be completed monthly times six months. The results of the audits will be reported to the QA/CQI committee for future recommendations. The audit will be completed by the DNS or her designee 5. April 3, 2013.	