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

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 _____	03/07/2012

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

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on March 05, 2012 and completed on March 07, 2012, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 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 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy/procedure, and staff interview, the facility failed to ensure residents were free of any significant medication errors for for 2 of 9 sampled residents (Resident #1 and #9). Failure to administer the correct medications and accurately transcribe physician's orders to a medication administration record (MAR) resulted in Resident #1 receiving 4 doses of an antidepressant that had been discontinued and the omission of 7 of 10 doses of a scheduled anti-anxiety medication for Resident #9. Findings include: Review of the facility procedure titled "Administration of Medication" occurred on 03/07/12. This policy, revised October 2009, stated, ". . . PROCEDURE . . . 4. Using the specific center's medication system, administer	F 333	F-333 1. Resident #1's medication was discontinued on 10/25/11. The medical record was updated, the pharmacy was notified and the MAR was updated. Resident #9's medication dose was clarified by the physician on 02/06/12. The medical record was updated, the pharmacy was notified and the MAR was updated. 2. All residents in the facility that require medication administration have the potential to be affected in this area.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3-26-12

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.

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F 333	Continued From page 1 medications to the resident according to the "Five Rights:" Right drug . . ." Review of the facility procedure "Physician's Orders" occurred on 03/07/12. This policy, revised September 2010, stated, ". . . Discontinued Orders . . . 32. If a current physician's order is changed (i.e., dosage change, frequency change, etc.), the current order must be discontinued and the new order processed per procedure. It is not acceptable to make a change in the current order for example, if a dosage changed from 1 to 2 tablets, is NOT acceptable to cross out the 1 and insert the 2 . . . Transcribing Orders . . . 37. If the order [physician's order] relates to a medication or treatment, write the new order on the Medication or Treatment Administration Record . . . Be sure the order is transcribed exactly as it was written on the original order . . . Recapping Orders . . . 50. At the end of each month, the printed Physician's Orders . . . in the medical record must be compared with the physician's orders in the Resident Services application. This is completed to ensure all orders received or discontinued throughout the month and documented in the medical record have been updated in Resident Services application before printing new Medication and Treatment Administration Records . . . for the next month . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included multiple sclerosis and dementia. The resident's physician ordered Lexapro (an antidepressant medication) 10 milligrams (mg) daily on 9/28/11 and discontinued the medication on 10/11/11 due to a possible intolerance.	F 333	3. A mandatory meeting for RN, LPN and CMA staff will be held 04/03/2012 to educate staff and review the policy and procedure for "Administration of Medications". The education includes a focus on medication confirmation of the physician order and the transcription of the medication change onto the MAR. 4. The first of three audits that will be developed is to verify that the pharmacy has been notified when a physician has ordered a change (including a new medication, a change in dosage, and discontinuation of medication). The second audit that will be developed includes verification that the	

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F 333	Continued From page 2 A fax communication to Resident #1's physician, dated 10/25/11, stated, "Med [medication] (Lexapro 10 mg PO [by mouth]) was d/cd [discontinued] due to intollerance [sic] on 10/11/11. She did not receive med until 10/21, 22, 23, 24 [October 21-24, 2011] as it was refilled by pharmacy as it was not communicated to them. Resident has had mental status [changes] over the past couple months - she has not displayed overt [changes] due to these xtra [extra] doses. (Med pulled [and] pharmacy updated)." Review of the incident report, dated 10/25/11, identified nursing staff administered the discontinued medication daily from October 21-24, 2012. The report stated, "med d/cd [and] given w/o [without] it being on MAR." Additional comments/interventions written on the incident form included, ". . . Lexapro 10 mg was in med cart [and] appears given past 4 mornings. CMA [certified medication aide] today brought card to CN [charge nurse] attention . . . Remind nurses to double [check] orders including pharmacy sheet . . . [checked] pharmacy sheet [and] D/C [discontinued] notice [not] on there. 2 CMAs missed it [and] noc [night] nurse [checking] order [illegible word] . . ." - Review of Resident #9's medical record occurred on 03/07/12. Diagnoses included dementia with psychotic features and anxiety. Medications included Xanax, an anti-anxiety medication. Resident #9's record contained a physician order, dated 01/14/12, for "Xanax 0.25 mg po [orally] every 6 hours PRN [as needed] anxiety," changed	F 333	nursing personnel properly compare the medication cassette with the MAR. The third audit that will be developed confirms on the 1st of each month that the new MAR has been verified to be accurate by a licensed nurse. The three audits will be completed monthly times three months. The results of the audits will be reported to the QA/CQI committee for future recommendation. The audit will be completed by the Director of Nursing or her designee. 5. April 11, 2012	

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F 333	Continued From page 3 on 01/19/12, to "Xanax 0.125 mg po BID [twice daily] *can have one additional PRN dose in 24 hours for anxiety." Review of Resident #9's MAR, dated February 2012, showed the printed 01/14/12 Xanax order with a line drawn through the 0.25 mg and "0.125 mg" handwritten above it, and "can have one additional PRN dose in 24 h. [hour] for anxiety" handwritten following it. On 02/06/12, facility staff discontinued this order from the February 2012 MAR and added the 01/19/12 Xanax order. The resident received one PRN dose of Xanax on February 03, 04, and 05, however, the facility staff failed to administer the scheduled doses of twice daily Xanax from February 01-05, 2012. Review of the incident report, dated 02/06/12, showed ". . . Failure to Document Medication Transcription error . . . Noted order rcd [received] 1-19-12 Xanax 0.125 mg po BID. Can have one additional PRN order in 24 hrs. Order written on MAR unclear due to PRN order. Only one cartrage [sic] noted in cart so med might have been missed if staff didn't [check] order against med." During an interview on 03/07/12 at 11:45 a.m., a nurse manager (#2) stated the night nurse checked the February MAR against the January MAR, and "started to correct the Xanax order on the February MAR, but didn't get the BID portion or discontinue the every 6 hour PRN." This nurse (#2) stated staff were instructed not to cross off part of an order, such as to change a dose, but to completely recopy an order that has changed.	F 333		
F 371 SS=B	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 4 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, and staff interview, the facility failed to prepare food under sanitary conditions in 1 of 1 kitchen. These practices have the potential to increase the risk of foodborne illness and can affect all residents who eat food prepared in these areas. Findings include: Review of the facility's policies "Equipment Sanitation" and "Cleaning Schedules" occurred on the afternoon of 03/06/12. The policy, dated May 2004, "Equipment Sanitation" stated, ". . . 1. Check each equipment item in dietary for cleanliness . . . 2. Follow manufacturer's instructions for disassembly and cleaning. . . ." The policy, dated May 2004, "Cleaning Schedules" stated, ". . . 2. Each dietary staff person will be responsible for knowing his or her assigned duty and carrying it out during the designated work shift. 3. Each person will then	F 371	F-371 1. On 03/06/2012 the small mixer, microwave and food processor were thoroughly cleaned and inspected by the Dietary Manager. 2. All residents who live in the facility have the potential to be affected by this deficient practice. Cleaning schedules will be reviewed and updated to ensure these items are included. 3. A mandatory dietary personnel meeting will be held 04/03/2012 to address policy and procedure for review of policy and procedures related to "Equipment Sanitation" and "Cleaning Schedules". Specifically, personnel will be educated regarding their individual responsibilities for each shift to check equipment and follow manufacturer's instructions for disassembly, cleaning and documenting on the cleaning schedule that the cleaning is completed.	

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F 371	Continued From page 5 date and sign the schedule after completing his or her cleaning duties. . . ." The main dietary tour of the kitchen occurred on 03/06/12 at 2:35 p.m. with an administrative dietary staff member (#1). Observation showed the following: *a small standing mixer covered with a cloth, identifying it as clean and ready for use, with a buildup of dried food splattered on the underside of the mixer head. *a microwave with a buildup of dried food splattered on its upper interior. *a food processor/blender with food debris on its interior surface. Review of the daily cleaning schedules for February 27, 2012 through March 5, 2012 showed the following: *small mixer initialed as cleaned by staff March 4 and not used March 5. *microwave initialed as cleaned March 5. During interviews on the afternoon of 03/06/12 and the morning of 03/07/12, the administrative dietary staff member (#1) confirmed dietary staff should clean the above equipment more thoroughly.	F 371	4. An audit will be developed to ensure that all steps are followed according to policy and procedure for the small mixer, microwave and food processor. Documentation of the cleaning schedule will be reviewed by the dietary manager. The audit will be completed twice per week for one month, then monthly times two months. The audit will be completed by the Dietary Manager or her designee. The results of the audits will be reported to the QA/CQI committee for future recommendation. 5. April 11, 2012	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	F-441 1. Resident #11 is receiving their nebulizer treatments with staff utilizing proper hand hygiene.	

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F 441	Continued From page 6 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the facility failed to follow infection control procedures for 1 of 1 supplemental resident (Resident #11) observed receiving a nebulizer treatment, and for 1 of 4	F 441	Residents #5 and #12 are being assisted in the dining room by staff that are not touching food with bare hands and washing hands or using hand sanitizer between resident meal service or contact between two residents that are needing assistance with meals. - per S. Kleven, DON fax 4/4/12 DL 2. All residents who live in the facility and require assistance with meals and residents that receive nebulizer treatments have the potential to be affected in this area. A list of residents that use nebulizer treatments will be generated and each resident will be audited for proper hand cleaning by staff. A list of residents that receive assistance at meals will be generated and the residents that require assistance at meals will be audited for proper hand hygiene by staff. and to be sure staff are not touching food with their bare hands. - per S. Kleven, DON fax 4/4/12 DL	

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F 441	Continued From page 7 sampled residents (Resident #5) and 1 supplemental resident (Resident #12) observed receiving assistance with eating. Failure to perform hand hygiene after direct resident contact and failure to prevent bare hand contact with residents' food does not provide a safe and sanitary environment and may contribute to the transmission of disease and infection. Findings include: Review of the facility procedure titled "Nebulizer" occurred on 03/07/12. This procedure, revised September 2010, stated, ". . . Procedure . . . 16. Following medication administration, rinse equipment with hot water and place on paper towel to air dry. Then wash hands. . . ." Review of the facility policy/procedure titled "Hand Hygiene and Handwashing" occurred on 03/07/12. This policy, revised November 2011, stated, ". . . If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning your hands: Before having direct contact with residents; After having direct contact with a resident's skin; . . . After touching equipment or furniture near the resident; After removing gloves. . . ." - On 03/05/12 at 4:45 p.m., observation showed a certified medication aide (CMA) (#3) entered Resident #11's room, cleansed her hands and gloved. The CMA placed Albuterol (medication for breathing disorders) in the nebulizer apparatus, placed the mask on Resident #11's face, turned on the nebulizer machine, adjusted the loose mask, removed her gloves, and left with room	F 441	3. A mandatory nursing personnel meeting will be held 04/03/2012 to review policy and procedures related to "Nebulizer" and "Hand Hygiene and Handwashing". and policy on proper Food handling. -per S. Kleven, DON fax 4/4/12 DL 4. An audit will be developed to ensure that all steps are followed according to policy and procedure for hand hygiene when administering nebulizer treatments. An audit will be developed to ensure that all steps are followed for proper hand hygiene while assisting residents with meals and meal service in the dining room. and to ensure there is no bare hand contact with Food at mealtime. -per S. Kleven, DON fax 4/4/12 DL The audits will be completed twice weekly for one month, then monthly times two months. The audit will be completed by the Infection Control Nurse or her designee. The results of the audits will be reported to the QA/CQI committee for future recommendations.	

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F 441	Continued From page 8 without performing hand hygiene. At 5:10 p.m., the CMA (#3) returned to Resident #11's room, gloved, rinsed the nebulizer apparatus and mask with water and placed them on a paper towel to dry, wiped the resident's face and eyes with a wet washcloth, removed her gloves, and left the room without performing hand hygiene. - On 03/06/12 beginning at 8:00 a.m., observation showed a licensed staff member (#4) assisting Resident #12 to eat breakfast. The staff member picked up the resident's toast with her bare hands every time she offered the resident a bite of toast. - On 03/06/12 at 8:25 a.m., Resident #5 arrived for breakfast. A licensed staff member (#4) performed hand hygiene, held the toast with her bare hand and used a knife to spread the toast with peanut butter and jelly. The staff member then picked up the toast with her bare hand and placed it in Resident #5's hand to feed herself. During an interview on 03/07/12 at 6:30 p.m., an administrative nurse (#5) agreed staff should not have bare hand contact with a resident's toast/bread.	F 441	5. April 11, 2012	