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 _____	03/10/2011

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 03/07/11 and completed on 03/10/11, the sample included 2 residents for complete review, 7 residents for complete review, and 1 closed record for review. The sample included 3 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 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility procedure, and resident and staff interview, the facility failed to ensure safe self-administration of medication (SAM) for 1 of 1 supplemental resident (Resident #11) self administering eye drops. Failure to determine if the resident could safely self-administer the eye drops placed the resident at risk for eye irritation or infection if the resident failed to use proper technique during administration. Findings include: Review of the facility procedure "Administration of Medication" occurred on 03/10/11. The procedure, revised January 2009, stated, "Self-Administration: The resident has the right to self-administer medication if the Interdisciplinary Team determines that this practice is safe for the individual resident and for others (this needs to be	F 176	**F-0176** **1. The artificial tears were immediately removed from Resident #11 room. Family and resident were educated on the need for assessment for self-administration of medication by the resident. Assessment for self-administration of medication was in the process when resident #11 passed away 3-27-11.** **2. All residents that self administer their own artificial tears have the potential to be affected in this area. A list of residents will be generated and each resident will have a self administration assessment completed.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

M L Clearwe — Administrator — 4-1-11

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 176	Continued From page 1 documented in the Care Plan). Nursing staff will be aware of medications kept in the room and responsible for recording self-administration doses in the resident's medical record." An initial tour of the facility occurred on 03/07/11 at 6:30 p.m. Observation in Resident #11's room identified a bottle of artificial tears on a table near the resident's recliner. Observation on 03/08/11 at 1 p.m. and 03/09/11 at 1:10 p.m. identified the bottle remained on the table in Resident #11's room. Resident #11's medical record, reviewed on 03/09/11, identified diagnoses including rheumatoid arthritis. The record failed to identify a physician's order for the artificial tears. The record lacked an assessment or care plan from the interdisciplinary team identifying Resident #11 as able to safely self administer medication. An "Interdisciplinary Assessment and Summary Note" for an annual Minimum Data Set, dated 02/16/11, stated, "[Resident #11] is A&O [alert and oriented] et [and] some forgetfulness may be noted." During an interview on 03/09/11 at 4:10 p.m., an administrative nurse (#1) stated Resident #11's family sometimes brings medication to the resident. She stated she was not aware of the eye drops in Resident #11's room. When interviewed, on 03/10/11 at 8:40 a.m., Resident #11 stated she "sometimes" uses the artificial tears as a "lubricant" for her eyes.	F 176	**3. A mandatory licensed personnel inservice on 4-12-11 to address the policy and procedure for self-administration of medications. A mandatory all staff meeting on 4-12-11 will address all departments and include the policy and procedure for self-administration of medication for general staff to have an awareness and report any new medications that they may find in a resident room. The policy and procedure will also be reviewed with residents and family upon admission to the facility and at care planning sessions.** **4. An audit will be developed to monitor resident rooms for any medications in order to determine if any residents need to be assessed for self-administration of medication. The audit will be completed weekly times four weeks, then monthly times two 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 14, 2011**	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

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F 225	Continued From page 2 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 225	**F-0225** **1. The incident of alleged abuse from 7-04-11 was reported to the State on 7-06-11. A thorough investigation of the allegation was completed on 7-06-11. Appropriate corrective action was taken after the investigation was completed and the staff member was allowed to return back to work. The results of the investigation were reported to the NDDH within 5 working days on 7-06-11.** **2. All residents who live in the facility have the potential to be affected by this deficient practice. The Good Samaritan Society is dedicated to the care and services of our residents and any and all allegations of abuse and neglect will be reported to the NDDH, investigated and the appropriate action will be taken to protect our residents from abuse and neglect.**	

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F 225	Continued From page 3 F225 IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 12/18/10. Based on review of facility investigations, facility policy and procedure, and staff interview, the facility staff failed to immediately report 1 of 2 allegations of abuse to the administrator of the facility and to the State survey and certification agency. Failure to immediately report allegations places all residents in the facility at risk of ongoing abuse, neglect, or mistreatment. Findings include: Review of the facility policy and procedures occurred on 03/09/11. The policy, titled, "Abuse and Neglect," revised 01/2009, stated, ". . . 5. Notification Procedures: a. Notify the center administrator immediately of any incidents of resident abuse . . . b. Notify the designated agencies in accordance with state law, including the state survey and certification agency . . ." Review of the facility abuse investigations occurred on 03/08/11 and identified an allegation of verbal abuse occurred on 07/04/10 at 6:00 a.m. A nursing staff member (#17) reported the allegation on 07/06/10, two days after the allegation occurred. During an interview on 03/09/11 at 9:30 a.m., the nursing staff member (#17) recalled the incident, but could not recall if she reported this immediately to the administrator. The staff member further stated had she reported the incident immediately, this would be reflected in the investigation report.	F 225	**3. A mandatory all staff meeting will be held 4-12-11 to re-educate on the policy and procedure for abuse and neglect reporting. A mandatory licensed personnel meeting will be held 4-12-11 to re-educate on the policy and procedure for abuse and neglect reporting. Emphasis will be placed on the timeliness of the initial reports to NDDH, Administrator and DNS to ensure that appropriate actions are put into place to protect the resident and start the investigations process.** **4. System Change:** **The daily communication sheets for Charge nurses have been updated to include an area that prompts Charge nurses to ask CNA's during report of any concerns or suspected allegations. CNA's have a daily work tool that has been updated to prompt CNA's to report any concerns or suspected allegations to the Charge nurse.** **An audit will be developed to monitor the daily review of the new communications tools with Charge nurses and CNA's to ensure timely reporting of any concerns or suspected allegations.**	

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F 225	Continued From page 4 During an interview on the morning of 03/10/11, two administrative nursing staff members (# 1 and #18) stated the expectation for facility staff is to report any allegations of abuse, neglect, or mistreatment to them immediately. These staff members agreed this situation posed a risk of harm to other residents in the facility. Failure to report the allegation in a timely manner delayed the facility's investigative process, placed other residents at risk of harm, and had the potential to allow the staff member with an allegation of abuse to continue working.	F 225	**The audit will be completed weekly times four weeks and monthly times two 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 14, 2011**	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility allegations, professional literature, and staff interview, the facility staff failed to promote care in a manner that enhanced each resident's dignity and respect for 1 of 1 closed record review (Resident #10) and 1 of 1 random dining observation. Findings include: The Centers for Medicare and Medicaid Services defines dignity in the following manner: ""Dignity" means that in their interactions with residents, staff carries out activities that assist the resident to maintain and enhance his/her self-esteem and	F 241	**F-0241** **1. The allegation of potential verbal abuse was investigated. The staff member was removed from the schedule until the investigation was completed. Appropriate actions were taken to protect resident #10 during the investigation. Resident #13 has a clothing protector to protect clothing from spills and extra napkins and washcloths are available at the table for staff to assist resident with wiping food from the face and chin.** **2. All residents who receive end of life care and receive any assistance from staff at mealtimes have the potential to be affected in this area. A list of residents that are currently on end of life cares will be generated and a list of residents that are assisted at meals will be generated and reviewed to ensure compliance in this area.**	

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F 241	Continued From page 5 self-worth. Some examples include (but are not limited to): . . . Promoting resident independence and dignity in dining . . . Respecting residents by speaking respectfully . . ." Review of the facility abuse investigations occurred on 03/08/11 and identified an allegation of verbal abuse occurred on 07/04/10 at 6:00 a.m. The allegation identified a nursing staff member (#19) told Resident #10, receiving end of life care, she wanted to 'kill him.' During an interview on 03/09/11 at 6:15 p.m., the nursing staff member (#19) stated the comments made to Resident #10 were "inappropriate." During an interview on the morning of 03/10/11, two administrative staff members (#1 and #18) agreed residents at end of life require dignified care and agreed the expectation for all staff is to provide care in a dignified manner. - Observation during the noon meal on 03/08/11 showed a CNA (#2) feeding a dependent resident (Resident #13). Throughout the meal, the CNA used Resident #13's clothing protector to wipe food from the resident's mouth/chin. During an interview on the afternoon of 03/09/11, an administrative nursing staff member (#1) stated she expected the staff to use a napkin to wipe residents' mouths and not a clothing protector.	F 241	**3. A mandatory all staff meeting was held 3-29-11 with on death and dying with dignity which was presented by Hospice. A mandatory all staff meeting will be held 4-12-11 with an emphasis on providing cares with dignity at all times. Napkin holders with extra napkins as well as washcloths are available at each assisted table to maintain resident dignity when wiping food from the mouth/chin.** **4. An audit will be developed to monitor verbal interactions with residents while providing cares to ensure dignity with all cares. An audit will be developed to monitor the appropriate use of clothing protectors and napkins in the dining room to ensure that residents maintain dignity when receiving assistance at meal times. The audits will be completed weekly times four weeks, then monthly times two months. The results of the audits will be reported to the QA/CQI committee for future recommendations. The audits will be completed by the DNS or her designee.** **5. April 14, 2011**	
F 280 SS=D	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	F 280		

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F 280	Continued From page 6 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 record review and staff interview, the facility staff failed to review and revise the plan of care for 1 of 2 sampled residents (Resident #8) with a history of aggression towards other residents and 1 of 2 sampled residents (Resident #2) with a multidrug-resistant organism (MDRO). Findings include: - Record review for Resident #8 occurred on 03/09/11. The medical record identified two incident reports, dated 01/01/11 and 01/13/11, stating Resident #8 hit another resident during an altercation. The reports indicated facility staff intervened and separated the residents. Review of Resident #8's current comprehensive care plan did not identify aggression towards	F 280	**F-0280** **1. Care plan for Resident #8 was revised 3-9-11 to include the specific history of aggression with specific interventions. Care plan for Resident #2 was revised 3-28-11 to include specific problems and interventions for the MDRO.** **2. All residents who live in the facility and have a specific history of agression and/or have an MDRO that requires specific problem identification and intervention have the potential to be affected by this deficient practice. The Good Samaritan Society is dedicated to the care and services of our residents.** **3. A mandatory licensed personnel meeting will be held 4-12-11 to address care planning for identified specific behaviors with interventions. A mandatory licensed personnel meeting will be held 4-12-11 to address specific interventions for residents with MDRO. Upon diagnosis of MDRO, the care plan will be revised to include specific problems and interventions for the resident. Residents with a history of aggression will have specific behaviors identified and interventions specific to those behaviors will be included in the revisions made to their care plans.**	

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F 280	Continued From page 7 other residents or specific interventions for staff to use. During an interview on the morning of 03/10/11, an administrative nursing staff member (#1) stated staff re-direct Resident #8 during these times and agreed Resident #8's care plan should reflect her history of aggression with specific interventions. Failure to incorporate Resident #8's history of aggression into the care plan, along with specific interventions for staff to implement, does not allow for consistency among staff or comprehensive care provided according to Resident #8's current needs and does not protect other residents from potential abuse. - Review of Resident #2's medical record occurred on March 7-10, 2011. A lab report, dated 05/27/10, identified vancomycin resistant enterococcus (VRE) on a rectal swab. A quarterly Minimum Data Set (MDS), dated 12/08/10, identified the resident required one person physical assistance with personal hygiene and had a MDRO. Review of Resident #2's care plan failed to identify a problem or interventions for the MDRO. Failure to develop a care plan which included approaches for Resident #2's VRE limited staffs ability to provide continuity of care.	F 280	**4. An audit will be developed to ensure that all care plans for residents with behaviors will be addressed for specific behaviors and interventions at the monthly behavior meetings. The audit 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 Social Worker or her designee. An audit will be developed to ensure that all residents with a current diagnosis of MDRO will have any problems or specific interventions addressed on the care plan. The audit 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 Infection Control Nurse or her designee.** **5. April 14, 2011**	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	**F-0281** **1. Transcription error was corrected and Resident #3 was immediately started on the multi-vitamin 3-1-11.**	

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F 281	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on record review, professional reference review, facility policy review, and staff interview, the facility failed to follow accepted standards of practice regarding medication administration for 1 of 9 sampled residents (Resident #3). Failure to transcribe a physician's order to Resident #3's medication administration record (MAR) resulted in the omission of a multivitamin for nearly one month. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 8th Edition, dated 2008, page 73, states, ". . . If the [physician's] order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ." Page 841 states, ". . . Communicating a Medication Order . . . A drug order is written on the client's chart by a primary care provider or by a nurse receiving a telephone or verbal order from a primary care provider. . . . The medication order is then copied by a nurse or clerk to a Kardex or MAR . . ." Review of the facility policy titled "Physician's Orders" occurred on 03/10/11. This policy, revised September 2010, stated, ". . . Fax Orders . . . 23. Upon return of the fax from the physician or when a new fax is received from the physician, the licensed nurse will transcribe the order per procedure . . . 37. If the order relates to a medication or treatment, write the new order on the Medication or Treatment Administration Record . . ." Review of Resident #3's medical record occurred	F 281	**2. All residents who live in the facility with medication orders have the potential to be affected by this deficient practice.** **3. A licensed personnel meeting will be held 4-12-11 with an emphasis on professional standards in regards to medication transcription.** **4. System change:** **A working tool will be created to ensure that doctor orders for medications are transcribed correctly onto the MAR.** **An audit will be developed to monitor doctor orders for medications have been properly transcribed to the MAR in a timely manner. The audit will be completed weekly times four weeks, then monthly times two 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 14, 2011**	

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F 281	Continued From page 9 on all days of survey. Diagnoses included diabetes mellitus, osteoarthritis, and weight loss. A "Fax Communication To Physician" form (completed by the nurse and faxed to the physician) located in Resident #3's medical record stated the following: ". . . 02/02/11 . . . Dietician recommendation to [increase] supplement to 3 oz [ounces] TID [three times a day] and [one] multivitamin [with] minerals po [by mouth] qd [every day]. Is this ok [with] you . . ." The physician responded via fax and stated, "OK." Resident #3's MAR for the month of February did not list a multivitamin as one of the resident's medications. Another "Fax Communication To Physician" form, dated 02/28/11, stated the following: ". . . you ordered a Multivitamin [with] mineral po Q [every] day on 2/3/11 - it was not transcribed on the MAR and error was caught when reviewing for new months MAR. We plan to start med. [medication] tomorrow. . . ." Review of Resident #3's MAR for the month of March showed the initiation of a daily multivitamin on 03/01/11. During an interview on 03/10/11 at 7:50 a.m., an administrative nursing staff member (#1) stated if staff receive a new medication order, she expected them to hand-write the order on the current MAR. She also stated the nurse forgot to transcribe the multivitamin order on Resident #3's February MAR.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		

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F 309	Continued From page 10 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility staff failed to provide the necessary pain management for 1 of 1 sampled resident (Resident #5) who expressed pain during therapy services. Failure to provide pain medication prior to therapy resulted in Resident #5 experiencing increased pain. Findings include: Observation of Resident #5's therapy session occurred on 03/08/11 at 1:10 p.m. A certified nursing assistant (CNA) (#23) assisted Resident #5 out of bed for therapy. Resident #5 stated, "I usually get a pain pill before I do therapy, what happened today?" The CNA replied, "I don't know." The CNA (#23) asked Resident #5 if she "wanted something," but then encouraged her to "walk first." The resident walked down the length of the hallway with the CNA, then sat in her wheelchair. The CNA transported her into the therapy room. A therapy staff member (#24) assisted Resident #5 to perform range of motion therapy to her left wrist, arm, and shoulder. Resident #5 voiced pain throughout the observation, stating "ouch." When this surveyor asked Resident #5 if she usually has pain during therapy, the Resident replied, "yes." At no time during the observation did Resident #5 receive pain medication or other pain interventions, despite verbalizing pain.	F 309	**F-0309** **1. Resident #5 was provided education regarding the right to pain management and pain medications are offered prior to each therapy session and pain during therapy sessions will be addressed immediately to provide the highest practicable physical, mental, and psychosocial well being.** **2. All residents who live in the facility with complaints of pain have the potential to be affected by this deficient practice. Pain assessments are conducted upon admission, quarterly and as needed if there are indications of pain.** **3. A mandatory licensed personnel meeting will be held 4-12-11 to address resident rights regarding pain management. Therapists and Restorative Aids will receive education with an emphasis on addressing the needs of residents with complaints of pain during therapy sessions.**	

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	355104	A. BUILDING _____ B. WING _____	03/10/2011

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F 309	Continued From page 11 Record review for Resident #5 occurred on March 08-09, 2011. The Minimum Data Set (MDS), dated 02/24/11, identified no memory problems, and occasional, moderate pain over the last five days. The MDS did not identify scheduled pain medication, or non-medication interventions for pain treatment. The facility identified Resident #5 as interviewable. The record identified Resident #5 experienced a fracture to her left humerous (arm) in January 2011. The current comprehensive care plan identified a temporary pain care plan, but did not address pain management during therapy or any non-pharmacological interventions to treat Resident #5's pain. Review of Resident #5's medication regimine identified the following medications for pain: Tylenol 650 milligrams (mgs) every six hours as needed; Lortab 5/500 (narcotic pain medication) 1-2 tablets every 6 hours as needed. Review of Resident #5's Medication Administration Records (MARs) occurred for January-March 2011. The January record identified pain medication given six times, the February record showed Resident #5 medicated seven times, two of which were for "pain control during therapy," with Lortab, for which the resident received good results, and the March record identified pain medication given twice. The records lacked a consistent pattern of pain medication coverage when Resident #5 participated in therapy. During an interview the morning of 03/10/11, two administrative staff members (#1 and #18) voiced understanding of the need for an effective pain	F 309	**4. An audit will be developed to ensure that residents complaining of pain will be offered pain management prior to and/or during therapy sessions. The audit will be completed weekly times four weeks, then monthly times two months. The results of the audits will be reported to the QA/CQI committee for future recommendations. The audit will be completed by the Rehabilitation Nurse or her designee.** **5. April 14, 2011**	

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F 309	Continued From page 12 management program to meet the needs of Resident #5. Failure of the staff to follow up with nursing regarding Resident #5's request for pain medication prior to therapy and verbalizations of pain during therapy, failure to provide a consistent treatment plan prior to therapy, and failure to implement other pain interventions caused Resident #5 to experience pain during her therapy session, which has the potential for Resident #5 not to receive the full benefit of therapy.	F 309		
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, and resident interview, the facility failed to provide reasonable accommodation of individual needs and preferences for 1 of 2 sampled residents (Resident #7) who utilized an electric wheelchair. Failure to ensure Resident #7 could safely utilize an electric wheelchair placed her and other residents at risk for injury. Findings include: Review of Resident #7's medical record occurred on March 09-10, 2011. Diagnoses included	F 323	**F-0323** **1. Occupational Therapy is in the process of evaluating Resident #7 to assess the resident for safety in using an electric wheelchair. The care plan will be updated after the evaluation.** **2. All residents that utilize electric scooters have the potential to be affected in this area. A list of resident that utilize electric wheelchairs will be assessed for proper and safe use of the electric wheelchair and care plans will be updated as needed.**	

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F 323	Continued From page 13 degenerative joint disease, rheumatoid arthritis, and cataracts. The current care plan, dated 02/09/11, stated, ". . . Problem . . . Sensory Perceptual Alteration: Visual r/t [related to] cataract OD [right eye] and cataract surgery OS [left eye] . . . Plans and Approaches . . . Avoid clutter in room. Keep open areas clear. . . ." The current Minimum Data Set (MDS), dated 02/04/11, identified Resident #7 as cognitively intact, and the facility identified Resident #7 as interviewable. Resident #7's medical record contained an assessment titled "Motorized Mobility Device Assessment." This assessment, completed in November 2009, indicated Resident #7 could safely propel herself with an electric wheelchair. Review of "Interdisciplinary Progress Notes" revealed the following: *10/06/10 at 4:00 p.m.: "Res [resident] c/o [complains of] not being able to see good enough to use electric chair et [and] has been asking staff to push it - Res. informed that the chair is heavy to push et she will need to use regular w/c [wheelchair] if she wants assist [sic]." The group interview occurred on 03/08/11 at 1:15 p.m. Resident #7 stated she could not see very well out of her left eye, and she would "like to get pushed" sometimes by staff. She stated the staff tell her they can't push her in the electric wheelchair because it is too heavy and they might hurt themselves. At the conclusion of the group interview, observation showed Resident #7 bumped into another resident's walker (located to the left side of Resident #7) while attempting to leave the	F 323	**3. System Change:** **Any resident that desires to have a motorized mobility device will have an Occupational Therapy assessment to determine if there are any potential safety issues when using the device. A mandatory all staff meeting to re-educate staff on Resident's Rights and the Accomodation of Needs will be held 4-12-11 to emphasize that we promote the highest level of independence by accommodating residents and their individual needs. Residents will be reviewed quarterly by the care planning team and any concerns related to accommodation of need will be addressed.** **4. An audit will be developed to ensure that resident's that utilize electric wheelchairs are assessed and monitored for safe usage of the device. The audit will be completed weekly times four weeks, then monthly times two 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 14, 2011**	

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F 323	Continued From page 14 room. After backing up and attempting to exit once more, observation showed Resident#7 again bumped into the other resident's walker. Resident #7 stated, "See what I mean? It's hard to steer this [wheelchair] through tight spaces." An individual interview occurred with Resident #7 on the afternoon of 03/09/11. During the interview, Resident #7 stated the following: * She would occasionally like staff to propel her in the electric wheelchair to meals and activities. * She ran over another resident's foot "about a month or so ago." * She bumped into another resident seated in a wheelchair "a couple weeks ago." * She often asks staff to help her maneuver in "crowded or tight spaces" but feels she can propel herself in open areas such as the hallway. * She has asked for help from staff within "the last few days" and "fairly often in the past." * In congested areas, she is worried she will run into someone/something and hurt other residents or herself. The record revealed, in October 2010, Resident #7 stated she could not see well enough utilize her electric chair and requested help from staff. Although Resident #7 continued to express the desire for assistance to propel her electric wheelchair, the facility failed to ensure Resident #7 could safely utilize the chair. This failure placed Resident #7 and other residents at risk for injury.	F 323		
F 363 SS=B	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition	F 363	F-0363 **1. Portion sizes for menu extensions are now available for dietary staff to reference at meal service times.**	

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F 363	Continued From page 15 Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility menus, facility policy review, and staff interview, the facility failed to meet the nutritional needs of residents by using incorrect utensil sizes during 1 of 2 observations of tray line (03/08/11 evening meal). Failure to use the correct utensil size has the potential to increase or decrease the portion size and impact the nutritional status of all residents who eat meals in the dining room. Findings include: Review of the facility policy titled "Portion Control" occurred on 03/10/11. This policy, revised March 2009, stated, ". . . Purpose . . . To ensure nutrient needs of residents are met. To ensure that the menu is served in the quantity stated by the menu writer. . . . Procedure . . . 1. The portion sizes listed on the menu extensions will be followed. Portion sizes for menu extensions must be referred to during meal service. . . . 2. Standard portion control scoops and ladles will be used. . . ." Observation of tray line occurred on 03/08/11 at 5:36 p.m. with the following inconsistencies noted between the scoop sizes used and the facility's menu: * Baked beans served with a one cup scoop (should have used a 1/2 cup scoop) * Gravy served with a one ounce ladle (should have used a two ounce ladle)	F 363	**2. All residents who live in the facility have the potential to be affected by this deficient practice. The Good Samaritan Society is dedicated to the care and services of our residents.** **3. A mandatory dietary personnel meeting will be held 4-12-11 to address nutritional needs and requirements of all residents with an emphasis on portion control. The proper portion sizes on the menu extensions will be followed and referred to during meal service. All of the proper scoop sizes needed for portion control will be used at all meal times.** **4. An audit will be developed to ensure that the proper scoop sizes for portion control are being used and the menu extensions for portion sizes are available for reference during meal service times. The audit will be completed weekly times four weeks, then monthly times two months. The results of the audits will be reported to the QA/CQI committee for future recommendations. The audit will be completed by the Dietary Manager or her designee.** **5. April 14, 2011**	

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F 363	Continued From page 16 * Tuna salad served with a 1/2 cup scoop (should have used a 1/4 cup scoop) * Pureed stew served with a 1/2 cup scoop (should have used a one cup scoop) * Pureed cole slaw served with a 1/4 cup scoop (should have used a 1/2 cup scoop) During observation of tray line, a dietary staff member (#13) stated, "I give half of the scoop for small portion diets. See, like this guy gets small portions so I give him half [of the scoop]." Observation showed the staff member dished the resident's meal by filling the one cup scoop approximately half full of stew and the 1/2 cup scoop approximately half full of cole slaw. During an interview on 03/09/11 at 4:15 p.m., a supervisory dietary staff member (#14) stated she expected staff to use two different sized scoops, one for regular-sized portions and one for small-sized portions. She also confirmed the inaccuracy of the scoop sizes listed above.	F 363		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425	**F-0425** **1. No residents were found to be affected by this practice.** **2. All residents that receive medications have the potential to be affected by this practice. The education to the staff and pharmacist and the system change will ensure other residents are not affected in this area. The Good Samaritan Society is dedicated to the care and services of our residents.**	

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F 425	Continued From page 17 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, review of facility procedure, and staff interview, the facility failed to ensure medications delivered by the pharmacy were secured in 1 of 1 medication room. Findings include: The facility procedure "Acquisition, Receiving and Dispensing of Medications" occurred on 03/10/11. The procedure, revised January 2009, stated, ". . . Licensed nursing staff and/or medications aides are responsible for receiving and reordering of medications per their pharmacy system. . . . Once medications are delivered they will be secured in the appropriate storage area (i.e. [that is] medication cart or medication room). . . ." A tour of the medication room occurred on 03/09/11 at 3:50 p.m. with two Certified Medication Assistants (CMA) (#7 and #8). When asked how medications are delivered and received, the CMAs stated the pharmacist delivers medications to restock the carts every other Thursday between 8 and 9 p.m.. One CMA (#7) stated the pharmacist brings a dolly with seven to nine boxes filled with carded medications and places the boxes outside the medication room. The CMA stated she puts the boxes in the medication room when she finishes	F 425	**3. Pharmacist was contacted and educated on proper procedure for delivery of medications.** **System change:** **Medication deliveries are to be handed off only to personnel that are authorized to immediately lock the medications in the medication room.** **A licensed personnel inservice will be held 4-12-11 to educate staff on the proper procedure for accepting medication deliveries and proper storage.** **4. An audit will be developed to monitor that the pharmacy personnel delivered medication to authorized personnel and that proper procedure for locking and storing medication was followed. The audit will be completed weekly times four weeks, then monthly times two 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 14, 2011**	

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F 425	Continued From page 18 her evening medication pass, at about 10 to 10:30 p.m. (1 1/2 to 2 hours after delivery). The CMAs (#7 and #8) stated the boxes do not lock, but have a lid that is closed with a plastic tab. Failure to place the medication boxes in the medication room immediately upon delivery, as per facility procedure, created an opportunity for unauthorized persons to gain access to the medications.	F 425		
F 441 SS=E	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. (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	F 441	**F-0441** **1. Resident #2 care plan was revised to reflect specific guidelines for contact isolation and signage in the room was replaced to reflect gowning and gloving for toileting and perineal care.** **Resident #4 was not affected by the practice of not cleaning the lift with the germicidal wipe. All contact surfaces of lifts are wiped down with a germicidal wipe prior to exiting the resident room.** **2. All residents who are lifted with a mechanical lift, are in contact isolation, or receive whirlpool baths have the potential to be affected by this deficient practice. A list of residents that are lifted mechanically will be generated to ensure cleaning is completed on the lift. A list of residents on isolation precautions will be generated and these residents will have their isolation sign reviewed and care plan updated as needed. The list of residents that receive whirlpool baths will be generated and reviewed to ensure they are free of infection.**	

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F 441	Continued From page 19 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, record review, review of manufacturer's instructions, policy and procedure review, and staff interview, the facility failed to follow infection control practices for 2 of 2 sampled residents (Resident #2 and #4) in contact isolation and for 1 of 1 facility bathtub. Failure to follow infection control practices could result in the spread of Multidrug-Resistant Organisms (MDROs) within the facility. Findings include: - Observation of cares for Resident #2 occurred on 03/08/11 at 9:30 a.m. A Certified Medication Assistant (CMA) (#12) entered Resident #2's room to apply a Fentanyl patch. Observation showed a sign outside the door and an identical sign inside Resident #2's room which stated, "Anyone entering this room must wear: gloves, gown. Contact Precautions." The CMA failed to don gloves or a gown when removing the used Fentanyl patch and applying a new patch to Resident #2's back. When asked under what circumstances she would wear a gown and gloves, the CMA (#12) stated staff need to gown and gloves when doing perineal cares.	F 441	**3. A mandatory all staff meeting will be held 4-12-11 to address wiping down all contact surfaces of the lifts with germicidal wipes prior to exiting resident rooms. The all staff meeting on 4-12-11 will also emphasize contact isolation signage and specific problems and interventions for residents with MDRO. The all staff meeting on 4-12-11 will also address the manufacturer's recommendations and facility procedure for proper disinfection of the tub.** **4. An audit will be developed to monitor that proper contact isolation procedures are followed with residents that have a known MDRO. An audit will be developed to monitor that contact surfaces of the lifts are being wiped down with a germicidal wipe prior to exiting resident rooms. An audit will be developed to monitor the contact time of the disinfectant in the tub. The audits will be completed weekly times four weeks, then monthly times two months. The results of the audits will be reported to the QA/CQI committee for future recommendations. The audit will be completed by the Infection Control Nurse or her designee.** **5. April 14, 2011**	

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F 441	Continued From page 20 An interview with an infection control nurse (#6) occurred on 03/08/11 at 9:35 a.m. When asked why Resident #2 has contact precautions, the nurse stated the resident had vancomycin resistant enterococcus (VRE) in her stool. She stated she would expect staff to gown and glove when providing perineal care. This expectation conflicts with the signage posted for Resident #2. On 03/08/11 at 9:55 a.m., observation showed two Certified Nursing Assistants (CNAs) (#9 and #10) responded to Resident #2's call light. Resident #2 requested to use the bathroom. Observation identified, when assisted to the toilet, the resident voided and had a bowel movement. One CNA (#9) wiped Resident #2's perineal and anal area. The CNA wore gloves, but no gown, while providing perineal care. Review of Resident #2's medical record occurred on March 7-10, 2011. A lab report, dated 05/27/10, identified VRE on a rectal swab. A quarterly Minimum Data Set (MDS), dated 12/08/10, identified the resident required one person physical assistance with personal hygiene and had a MDRO. Review of Resident #2's care plan failed to identify a problem or interventions for the MDRO. During an interview, on 03/08/11 at 10:05 a.m. an infection control nurse (#6) stated the staff member should have worn a gown when providing perineal care for Resident #2. Failure to develop a care plan which included approaches for Resident #2's VRE and to ensure appropriate signage in her room resulted in staff not being aware of when to use protective	F 441		

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GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

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F 441	Continued From page 21 equipment while providing care. Review of the facility policy titled "Procedure for Cleaning Portable Equipment" occurred on 03/10/11. This undated policy stated, ". . . Purpose: To disinfect equipment that is taken into individual rooms and prevent possible cross contamination from resident to resident. Procedure: 1. Cleaning of portable equipment . . . A. Use a germacidal [sic] wipe to wipe down the item that was used. . . . D. Remove the portable equipment item from the residents [sic] room . . . Follow these steps each time the item is used in a resident room." - Review of Resident #4's medical record occurred on March 08-09, 2011. Diagnoses included a methicillin-resistant staphylococcus aureus (MRSA) infection in the resident's urine. Resident #4's care plan indicated the need for contact isolation precautions. Observation on 03/08/11 at 9:40 a.m. showed two CNA's (#2 and #3) entered Resident #4's room with a sit-to-stand mechanical lift. After using the lift to transfer the resident into bed, a CNA (#3) took the lift directly into another resident's room without sanitizing it. Observation on 03/08/11 at 4:54 p.m. showed two CNA's (#4 and #5) entered Resident #4's room with a sit-to-stand mechanical lift. After using the lift to transfer the resident into his wheelchair, the CNA (#4) removed the lift from the room and placed it in a storage closet, failing to sanitize the lift before leaving Resident #4's room. During an interview on the afternoon of 03/09/11, an administrative nursing staff member (#1)	F 441		

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 _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 22 stated she expected the staff to sanitize lifts after each use with all residents. - An interview took place on 03/08/11 at 8:40 a.m. with the bath aide (#20). During this interview, the staff member (#20) stated she cleans and sanitizes the tub after each resident bath. This staff member stated she leaves the chemical solution on for about 5-8 minutes, then scrubs the tubs and rinses with water. Review of the tub manufacturer's instructions occurred on 03/09/11. The instructions, dated 02/05, stated, " . . . Disinfecting Procedure . . . All disinfectants require sanitizing (pre-cleaning of heavily soiled surfaces before application.) Disinfectants need to be left on a moist surface for 10 minutes to be effective. . . ." During the environmental tour of the facility, on 03/09/11 at 2:30 p.m., the environmental supervisory staff members (#21 and #22) verified the chemical contact time for disinfecting the facility tub needs to be at least 10 minutes. Observation of staff cleaning the facility tub took place on 03/10/11 at 8:30 a.m. The bath aide (#20) cleaned/sanitized and disinfected the tub and, after a period of 5 minutes, rinsed the tub and wiped it dry. This staff member stated she received training on cleaning the tub, but she could not recall what was said. Failure to follow the manufacturer's recommendations and facility standards for cleaning the tub has the potential to spread infection throughout the facility.	F 441		