STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8205	A. BUILDING: _____ B. WING _____	10/17/2023

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) COMPLETE DATE
B 000	INITIAL COMMENTS For the unannounced licensure survey, started on 10/16/23 and completed on 10/17/23, the sample included 4 records for review. Tier II citations included B1540, and B2000.	B 000		
B1540	33-03-24.1-15,4 PHARMACY/MED ADM SERVICES 4. All medications used by residents which are administered or supervised by staff must be: a. Properly recorded by staff at the time of administration. b. Kept and stored in original containers labeled consistently with state laws. c. Properly administered. This State Licensing Rule is not met as evidenced by: Based on observation, record review, review of facility policy, manufacturer's guidelines, and staff interview, the facility failed to ensure proper administration of medications for 2 of 3 sampled residents (Resident #2 and #3) observed during medication pass. Failure to properly prime an insulin pen, administer medications per manufacturer's guidelines, and ensure medications are not left at the bedside may result in medication errors. Findings include: Review of the policy titled "Medication Administration" occurred on 10/17/23. This policy,	B1540	1) Resident #2 will be re-assessed by a nurse and a provider on whether or not he can self-administer his inhaler. We will follow proper protocol for self-administration after that point. Resident #3 and all nurses will be educated on proper infection control practices as relates to insulin injections, as well as manufacturer's instructions on Victoza. 2) All residents have the potential to be affected by this deficient practice. 3) In addition to #1, education will also be provided to all nurses and residents whom self-administer medications on the proper infection control and manufacturer's instructions as relates to self-administration of medication. 4) The corrective action and education will be completed by 11/28/23. 5) The Director of Nursing or designee will monitor the corrective action. Audits will be completed on proper documentation of and actual self-administration of medication, including following infection control and manufacturer's instructions, with the following frequency - weekly for one month, every other week for two months, and every month for three months.	11/28/23

Health Repsonse and Licensure
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/17/23

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B1540	Continued From page 1 dated 05/01/23. stated, ". . . Insulin Pen Use . . . Wipe the tip of the pen where the needle will attach with an alcohol swab . . . Turn the dosage knob to 2 units to prime the pen . . . Holding the pen with the needle pointing upwards, press the button . . ." Review of the manufacturer's guidelines for Victoza (diabetic medication) occurred on 10/17/23. This medication guide stated, ". . . You may give an injection of Victoza and insulin in the same body part (such as your abdomen area), but not right next to each other. . . ." - Observation on 10/16/23 at 1:00 p.m. showed a Ventolin inhaler at Resident #2's bedside. The resident stated, "[I] take when I need it [inhaler] when [I] have trouble breathing." Review of Resident #2's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease (a lung disease). A Self-Administration of Medication Evaluation, dated 04/24/23, stated, ". . . Is resident capable of self administering medications . . . No . . ." Staff failed to properly store all medications by leaving an inhaler in Resident #2's room and prevent self-administration of a medication when Resident #2 assessment showed incapable of self-administration. - Observation of medication pass occurred on 10/16/23 at 4:55 p.m. The licensed nurse (#4) observed as Resident #3 prepared two medications for injection. Resident #3 failed to wipe the tip of the pens with an alcohol swab prior to attaching the needles and primed both needles holding the pens horizontally. Resident #3 administered Novolog insulin and Victoza in her	B1540		

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B1540	Continued From page 2 abdomen right next to each other. The nurse (#4) failed to intervene and assist the resident with the correct procedure for administering both injections. During an interview on 10/17/23 at 3:05 p.m., an administrate staff member (#2) stated she expected staff to prime an insulin pen while held upright and expected the nurse to intervene if not done correctly.	B1540		
B2000	33-03-24.1-20 HOUSEKEEPING/LAUNDRY SERVICES 33-03-24.1-20. Housekeeping and laundry services. The facility shall maintain the interior and exterior of the facility In a safe, clean, and orderly manner and provide sanitary laundry services, including personal laundry services, for residents. This State Licensing Rule is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure a safe, clean, comfortable, homelike environment for 2 of 2 sampled residents (Resident #2 and #3) with a personal fan. Failure to clean personal fans does not provide a clean, comfortable/homelike environment and has the potential to place residents at risk for illness. Findings include: - Observation on 10/16/23 at 1:00 p.m. showed a fan in Resident #2's room. The outside covering/grate and fan blade fan contained large amounts of visible dust.	B2000	1) Residents #2 and #3 had the affected fans removed from their rooms on 10/16/23. 2) All residents have the potential to be affected by this deficient practice. 3) Residents #2 and #3 had the affected fans removed from their rooms on 10/16/23. Education to be provided to the housekeeping staff regarding the policy of no personal fans in basic care, as well as proper housekeeping practices. 4) Residents #2 and #3 had the affected fans removed from their rooms on 10/16/23. The education will be provided to housekeeping staff by 11/28/23. 5) The Social Worker or designee will be responsible for educating new admissions into basic care on the policy of no personal fans in rooms. In addition, the Supervisor of Ancillary Services or designee will routinely check rooms for the existence of fans and will notify Social Worker or designee to contact the resident representative to remove the fan, if it is present. Audits will be completed to check for the existence of a personal fan and verify that the room is clean (according to "Standard or Light Cleaning – Rehab/Skilled" policy) in each basic care room once Audits will be completed weekly for one month, every other week for two months, and every month for three months.	

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B2000	Continued From page 3 Review of Resident #2's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease (a lung disease). - Observation on 10/16/23 at 3:30 p.m. showed a fan in Resident #3's room. The outside covering/grate and fan blade fan contained visible dust. During an interview on the morning of 10/17/23, an administrative staff member (#1) confirmed the fans needed cleaning and placed the fans in the garage for staff to clean.	B2000		