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 _____	C 11/07/2022

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 An unannounced onsite complaint investigation survey was completed on October 31-November 7, 2022. The concerns identified by the complainants were partially substantiated.	F 000		
F 578 SS=G	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility	F 578		12/2/22

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

Electronically Signed | 11/27/2022

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F 578	Continued From page 1 may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, policy review, and staff interview, the facility failed to ensure the resident's right to request, refuse, and/or discontinue treatment for 2 of 9 sampled residents (Resident #1 and Resident #3) and 1 closed record resident (Resident #4) reviewed for advanced directives. Failure to ensure all methods of communication and/or documentation of code status accurately reflected the resident/resident representative wishes has the potential to limit his/her access to life-sustaining services or unwanted treatment, and did result in unwanted treatment for Resident #4. Findings include: Information provided by the complainants indicated that residents expressed different wishes for code status than what were ordered in the residents medical record resulting in unwanted treatment. Review of the facility policy titled "Advanced Directive including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) - Rehab/Skilled" occurred on	F 578	1)Resident #1 and #3□s code statuses were placed in their medical record on November 1, 2022. Resident #4□s status could not be updated as this was a closed record. 2)All resident charts were reviewed and, if no code status was present, code status was immediately entered on November 1, 2022. 3)The admissions procedure for our facility was re-vamped on October 25, 2022, which included collecting code status before a resident is admitted, completing the POLST discussion upon admission, and receiving provider signature on the POLST paperwork as soon as possible. Code status is also reviewed at each care plan, at least quarterly. Education was initiated on October 31, 2022, by Director of Nursing (DNS) to all nursing staff on policy "Advanced Directive including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) - Rehab/Skilled". Admission team	

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F 578	Continued From page 2 11/01/22. This policy, revised 07/21/22, stated, ". . . Residents have the right to formulate advance directives. . . .1. If cardiac arrests occurs, [sic] CPR must be initiated unless the resident has: a. A valid DNR [Do Not Resuscitate] order on file that includes the medical order issued by a physician or other authorized non-physician practitioner. . .Procedure: Admission/Re-Admission Advance Directive 1. At the time of admission or re-admission, social services or designated staff member asks the resident/healthcare decision-maker whether the resident has prepared an advance directive such as a living will, durable power-of-attorney for healthcare decisions . . . 2. The designated staff member will meet with the resident/healthcare decision-maker to answer questions and determine if the resident/healthcare-decision maker wish to develop or amend advance directives. . . . 4. As necessary, physicians will be contacted for orders that reflect the resident's wishes. . . .Procedure: Quickly Identifying Resident CPR status in the SNF [skilled nursing facility] . . . 2. When PCC [Point Click Care, electronic medical record] is available, the nurse may choose to access the code status on the dashboard. . . ." During an interview on 10/31/22 at 3:45 p.m., a staff nurse (#3) stated she verified resident code status by looking at the banner in the electronic medical record. The staff nurse (#3) accessed Resident #1's medical record and looked at the banner. No code status displayed. She stated "I would treat this resident as a Full Code." She indicated that is how she was trained as a nurse and did not recall if she received any specific training to code status on orientation.	F 578	will be educated by administrator or designee on the requirements for timely physician□s orders that reflect each resident□s wishes for code status. Education will be completed by December 2, 2022. 4)Audits will include that the advanced directives/code status are in the medical record as an order and in the banner on each resident chart before the time of admission for every new and re-admission once per week for two months, every two weeks for two months, and every month for two months. These audits will be the responsibility of the Social Worker or designee. If it is found that code status is not in the medical record or banner, the order will be immediately placed via telephone order. Any findings or issues will be discussed at our weekly interdisciplinary meeting and integrated into quality assurance. 5)The corrective action will be completed by December 2, 2022.	

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F 578	Continued From page 3	F 578		

Review of Resident #1's medical record occurred on all days of survey. A physician's order, dated 09/09/22, stated "Full Code." The electronic medical record failed to display Resident #1's code status in the area direct care staff would access prior to providing life sustaining treatment.

Review of Resident #3's medical record occurred on all days of survey. A physician's order, dated 09/23/22, stated "Full Code." A social service progress note, dated 09/23/22, stated, ". . . reviewed his advance directives with resident, and it continues to be DNR, DNI [Do Not Intubate], no tube feeding, Do hospitalize, and use antibiotics . . . " The electronic medical record lacked an updated physician's order reflecting the resident's wishes for code status and failed to display Resident #3's code status in the area direct care staff would access prior to providing life sustaining treatment.

Review of Resident #4's closed record occurred on all days of survey. A physician's order, dated 10/14/22, stated, "Full Code." A social service progress note, dated 10/14/22, stated, ". . . Advance directive was reviewed on admission, and it continues to be DNR, DNI, tube feeding only on a trial basis. He also agreed to the use of antibiotics. POLST [Physicians Order for Life Sustaining Treatment Form] will be sent to his primary for orders. . . . "

Review of nursing progress notes for Resident #4 showed the following:
* 10/21/22 at 10:14 p.m., stated, "At approximately 2030, CN [charge nurse] and CNA

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F 578	Continued From page 4 [certified nursing assistant] heard residents bed alarm going off. CN went in to check on him and he was on his knees with his torso laying over the bed. CN called for CNA to come assist him back into bed. As we were in the process of trying to get him back into bed, he slumped over and we lowered him the rest of the way to the floor. CN noted that he was cyanotic [bluish coloring of the skin due to lack of oxygen], eyes were glazed over and CN could not find a pulse. CN started CPR and did it over about a minute when resident started to gasp for air and started looking around. In the process CN yelled for CNA to call 911 and report a transfer for a resident who was unresponsive. CN told med aid to go grab an O2 [oxygen] concentrator and start oxygenating him. We got the O2 on him and his color started coming back. Resident still was not responding, but was looking around and would occasionally make a moaning sound. Ambulance showed up and transferred resident to the [critical access hospital] ER [emergency room]. . . . resident was currently intubated. [Physician name] (ER doctor) stated that they were going to air lift resident to the [acute care] hospital where he would be admitted to the ICU [intensive care unit]. . . ." * 10/24/22 at 12:03 p.m., stated, "Rec'd [received] signed POLST from MD [medical doctor]. . . " The facility failed to obtain an updated physician's order reflecting the resident's wishes for code status in a timely manner resulting in Resident #4 receiving CPR. The electronic medical record failed to display Resident #4's code status in the area direct care staff would access prior to providing life sustaining	F 578		

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F 578	Continued From page 5 treatment. During an interview on 11/01/22 at 8:45 a.m., two administrative staff members (#1 and #2) confirmed the medical records lacked updated physician's orders for Resident #3 and Resident #4, the physician's orders present in the medical record did not match the documented conversations, and Resident #4 received CPR per facility policy. They confirmed the electronic medical records for all three residents failed to display the code status in an area direct care staff would access prior to providing life sustaining treatment. The administrative staff members (#1 and #2) identified the facility failure to obtain revised physician's orders for code status and provided meeting minutes that showed implementation of a new admission process that began on 10/25/22. Education to nursing staff began on 10/31/22.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580		12/9/22

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F 580	Continued From page 6 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, review of facility	F 580	1) The corrective action for Resident #4 cannot be completed, as this resident was	

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F 580	Continued From page 7 policy, review of professional reference, and staff interview, the facility failed to notify the resident's physician of a change in condition for 1 of 1 closed record resident (Resident #4) who experienced low oxygen saturation levels and mental changes. Failure to notify the physician of these changes may have prevented the physician from altering the treatment/care provided to the resident. Findings include: Information provided by the complainant indicated nursing staff failed to communicate information regarding the resident's condition to the provider. Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, pages 63, 538-540, 1283-1284 stated, ". . . The nurse is considered responsible for notifying the primary care provider of any significant changes in the client's condition . . . Normal oxygen saturation [SpO2] is 95% to 100%; below 90% should be evaluated and treated, and below 70% is life-threatening. . . . Document the oxygen saturation on the appropriate record . . . Compare the oxygen saturation to the client's previous oxygen saturation level . . . Conduct appropriate follow-up such as notifying the primary care provider . . . Hypoventilation (reduced amount of air) . . . may be caused by either slow or shallow breathing, or both. Hypoventilation may occur because of diseases of the respiratory muscles, drugs, or anesthesia. Hypoventilation may lead to . . . low levels of oxygen . . . If the cardiovascular system is unable	F 580	discharged on October 21, 2022. 2) All residents have the potential to be affected by this same deficient practice. 3) Education will be provided for all nursing staff and all members of the admission team on the importance notifying the provider of changes. All resident medical records will include baseline vital signs, blood sugars, height, weight and pain level by December 9, 2022. Admission Orders will include under which circumstances the provider must be notified, as relates to physical condition and vital signs by December 9, 2022. 4) Audits will include that any resident physical changes outside of the defined parameters should include notifying the physician. These audits will be done on three random residents weekly for two months, every other week for two months and every month for two months. These audits will be the responsibility of the Director of Nursing or designee. 5) The corrective action will be completed by December 9, 2022.	

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to compensate or hypoxemia is severe, tissue hypoxia (insufficient oxygen anywhere in the body) results, potentially causing cellular injury or death . . . The face of the acutely hypoxic individual usually appears anxious, tired, and drawn. . . ."

Review of the facility policy titled "Notification of Change-R/S LTC [Rehabilitation/Skilled & Long Term Care]" occurred on 11/01/22. This policy, revised 04/26/22, stated, ". . . A facility must immediately . . . consult with the resident's physician . . . when there is: . . . 2. A significant change in the resident's physical, mental, or psychosocial status 3. A need to alter treatment significantly . . . to commence a new form of treatment . . . "

Review of the facility policy titled "Pulse Oximetry," revised 01/26/22, stated, ". . . Procedure . . . 6. If findings are 90 [percent] or below, have resident cough or take deep breaths and recheck. If findings continue to be low, contact physician. 7. Record the findings after the readings have stabilized and document results, noting if at rest or during activity . . ."

Review of Resident #4's medical record occurred on all days of. Diagnoses included Arnold-Chiari Syndrome with hydrocephalus (brain tissue extends into the spinal canal with buildup of fluid in the brain), presence of a cerebrospinal fluid drainage device (shunt), chronic continuous use of opioids, and anxiety.

Resident #4's care plan stated:
*"The resident has cerebral subarachnoid shunt placed . . . Interventions: . . .

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Monitor/document/report to health care provider s/s [signs or symptoms] of shunt malfunction: headache, decreasing mental capabilities, restlessness, irritability, . . . difficulty walking . . ."
*"The resident is a risk for falls . . . Interventions: . . . Review as indicated for significant changes in cognition, safety awareness and decision-making capacity . . ."
*"The resident has chronic pain/discomfort R/T [related to] [diagnosis] . . . Chronic physical disability . . . Interventions: . . . Observe and report changes in usual routine, . . . decrease in functional abilities . . ."

During an interview on 11/01/22 at 11:15 a.m., a staff nurse (#3) identified she had assessed Resident #4 and found his SpO2 less than 90% on multiple occasions on 10/21/22. She stated, "If he was just laying there relaxing they could be in the 60's but if he took some deep breaths they would come back up." She further identified it had occurred a couple times when she had cared for him during his admission. She identified the resident was confused if awakened but that he stated that was his normal. She stated she did not document the low SpO2 and did not contact the provider. She stated she did report the low oxygen levels to the oncoming nurse.

During an interview on 11/01/22 at 11:41 a.m., a staff nurse (#4) stated, "No I did not get report about low oxygen levels for Resident #4 that day," referring to 10/21/22. The nurse stated, "I did get report about low oxygen sats [saturations/levels] on previous days in report from [staff nurse #3]." The staff nurse (#4) stated, "I assessed him on one of his first nights (10/14/21) and found his SpO2 levels to be 65%.

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I repositioned him, had him sit up straighter, take some deeper breathes and they came up to 91%." She agreed she did not document the episode and did not notify the provider as she did not feel it was cause for concern since the levels increased with her interventions.

In a statement provided by the facility, signed and dated 11/02/22, the staff nurse (#3), stated, ". . . worked with Resident #4 on . . . October 21, 2022 . . . Resident was confused at times, but when I assessed him, he was alert, oriented to self, place, date and time. Per resident's mother's request, I did check resident's O2 sats several times throughout my shift. Resident would be sating low (83, 84, 76), but with a few deep breaths (in his nose, out his mouth) resident would sat 90, 91. My nursing judgment [sic] was resident was within normal limits as he would bounce up. I would have been concerned and followed up with MD [medical doctor] if resident's sats would have maintained less than 90%."

Review of Resident #4's vital sign documentation failed to show any SpO2 less than 90% documented.

Review of the nursing progress notes and a fax sent to Resident #4's physician showed the following:
* 10/14/22 at 5:29 p.m., "Admitted to Medicare A for follow up therapies . . . Did have a recent hospital stay for complications from his [diagnosis] with Hydrocephalus. and did have follow up care from surgery for different shunt placement due to Migraines and presence of cerebrospinal fluid in drainage device. . . . Nursing to monitor Vitals [signs] . . . Mood and

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F 580	Continued From page 11 behavior concerns. . . ." * 10/20/22 at 7:05 a.m., stated, "Heard resident yelling, cursing, CNA [certified nursing assistant] went to assist resident. Resident was sitting on the floor between his bed and his wheelchair. Resident was trying to put on his shoes. Resident very angry, refusing my assessment. Resident was flopping around on the floor determined to put his shoe on. Finally resident allowed CNA to assist him with shoes. . . ." * 10/20/22 at 8:25 a.m., "Heard resident yelling, cursing, CNA went to assess; resident sitting on the floor again between his wheelchair and bed. Resident refused assessment until up in bed. CNA assisted resident to bed. No injuries noted, denies pain." *Review of a fax sent to the provider on 10/20/22 at 11:31 a.m. stated, "Concern: Resident had 2 falls this morning trying to transfer himself without assistance. Resident was very angry, cursing that he fell. Can we please have something for increased anxiety/agitation?" The fax failed to include the instances when nursing staff checked Resident #4's oxygen saturation and found readings less than 90 percent and staff instructed him to deep breathe. * 10/21/22 at 10:01 a.m., stated, ". . . mother . . . Advised of resident's vital signs per her request . . . " Nursing staff could only inform Resident #4's mother of normal vital signs because the abnormal findings, low oxygen saturation readings, were not documented. * 10/21/22 at 1:00 p.m., ". . . Mother called, voiced concerns of resident being very confused, c/o not able to move extremities, trying to clean house, looking for family. Checked on resident, voiced waking from a deep sleep and being confused. Resident knows where he is and the	F 580		

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 _____	C 11/07/2022

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 580	Continued From page 12 date. . . ." Nursing staff failed to notify the resident's physician regarding signs/symptoms of possible shunt malfunctions as per care plan. * 10/21/22 at 10:14 p.m., "At approximately 2030 [8:30 p.m], CN [charge nurse] and CNA heard residents bed alarm going off. CN went in to check on him and he was on his knees with his torso laying over the bed. CN called for CNA to come assist him back into bed. As we were in the process of trying to get him back into bed, he slumped over and we lowered him the rest of the way to the floor. CN noted that he was cyanotic, eyes were glazed over and CN could not find a pulse. CN started CPR [cardiopulmonary resuscitation] and did it over about a minute when resident started to gasp for air and started looking around. . . . O2 on him and his color started coming back. Resident still was not responding, but was looking around and would occasionally make a moaning sound. Ambulance showed up and transferred resident to the [critical access hospital] ER [emergency room]. . . ." During a telephone interview on 11/07/22 at 10:30 a.m., an administrative nurse (#2) confirmed she expected nursing staff to document abnormal assessments, abnormal vital signs, and notify the provider and family of changes in resident status.	F 580		