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 _____	01/29/2015

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 January 26, 2015 and completed on January 29, 2015, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy and procedure, the facility failed to ensure 2 of 2 sampled residents (Resident #6, and #8) and 1 supplemental resident (Resident #11) observed with positioning concerns received reasonable accommodation of individual needs regarding dining room table positioning. Failure to offer and provide appropriate dining room table height resulted in the residents having difficulty eating . Findings include: Review of the facility policy titled "Dining Room Guidelines" occurred on 01/29/2015. This policy, dated June 2012, stated, "Purpose: To provide	F 246	F 246 1. Resident #6 and #8 will be placed at an adjustable dining table that is at an appropriate height. This will provide optimal positioning, which includes adequate distance from the table and wheelchair arms fitting under the table. Resident #11 will be assessed to determine his or her individual needs, cultural preferences and food preferences, adaptive feeding devices, assistance with eating or need for a restorative program. 2. In addition to an initial assessment upon admission, each resident will be re-assessed for dining positioning. Any modifications needed will be executed in a timely manner by restorative nursing staff. All residents will continue to be assessed to determine his or her individual needs, cultural preferences and food preferences, adaptive feeding devices, assistance with eating or need for a restorative program. 3. A mandatory in-service training related to dining positioning will be performed by the Director of Nursing Services and Nurse Managers and will be attended by all nursing and dietary staff.	3/5/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2/24/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	01/29/2015

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 246	Continued From page 1 guidelines for the center dining room . . . 6. For residents who must remain in their wheelchairs or other adaptive chairs, care should be taken to ensure that each person is at an appropriate height and distance to the table and is in a functional position for feeding self. . . ." Review of the facility policy titled "Dignity" occurred on 01/29/2015. This policy, dated February 2013, stated, "Purpose: To provide care in a manner that enhances resident dignity regarding dietary aspects . . . Procedure: 1. Dietary staff will promote resident independence and dignity in dining by: . . . i. Adjusting heights of tables and/or chairs so that residents are positioned properly . . . " - Observations during all days of survey identified Resident #6, #8, and #11 seated at the table in the dining room in wheelchairs. The observations showed the arms of the wheelchairs unable to fit under the table. - Observation during breakfast on 01/27/15 and 01/28/15, showed Resident #6 held his cereal bowl up to his chest to eat. - Observation during the evening meal on 01/27/15 showed Resident #6 and #8 held their soup bowls up to their chest to eat. Observations showed both residents had spilled soup on their clothing protectors.	F 246	4. A positioning audit will be done weekly for the duration of one month, then monthly for the duration of six months with all results reviewed by the QAPI Team. This audit will be the responsibility of the Director of Dietary Services or designee. If sufficient compliance is not evident, further training will be scheduled. If continued noncompliance by any staff member occurs, it will be met with disciplinary action on a case-by-case basis. 5. The mandatory in-service performed by the Director of Nursing Services and Nurse Managers and will be completed on March 3, 2015. Positioning audits related to dining will begin the week of March 2, 2015.	
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	F 280 1. The care plan of resident #4 was updated on January 30, 2015 to reflect the discontinuation of her restorative program. The care plan of resident #6 was updated on January 30, 2015 to reflect the discontinuation of his PICC line. The care plan of resident #2 was updated on January 30, 2015 to reflect her fall risk.	3/5/15

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 _____	01/29/2015

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 280	Continued From page 2 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 observation, record review, and staff interview, the facility failed to review and revise care plans to reflect residents' current status for 3 of 9 sampled residents (Resident #2, #4, and #6). Failure to update residents' care plans as needed limits staff's ability to ensure continuity of care. Findings include: - Review of Resident #4's medical record occurred on all days of survey. The resident's current care plan (initiated 01/30/14) stated, ". . . The resident has a need for restorative intervention due to history of falls. . . . Interventions . . . NURSING REHAB #1: Walking with assist of 2 with wheeled walker and gait belt-can go 10-25 feet. Encourage to participate and stand up tall, vocal commands to scoot butt	F 280	2. The care plans are reviewed quarterly and will have timely updates. Care plans will be reviewed in regard to restorative therapy and mobility assistance, fall risk, and IV lines. 3. A mandatory in-service training related to the review of care plans will be performed by the Director of Nursing Services and Nurse Managers and will be attended by all licensed personnel. 4. A care plan audit will be done weekly for the duration of one month, then monthly for the duration of six months with all results reviewed by the QAPI Team. This audit will be the responsibility of the Director of Nursing Services or designee. If sufficient compliance is not evident, further training will be scheduled. If continued noncompliance by any staff member occurs, it will be met with disciplinary action on a case-by-case basis. 5. The mandatory in-service performed by the Director of Nursing Services and Nurse Managers and will be completed on March 3, 2015. Care plan audits related to the importance of "review and revise" will begin the week of March 2, 2015.	

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 _____	01/29/2015

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 280	Continued From page 3 forward and lean forward to stand up from wheelchair. . . ." Observations throughout the survey showed Resident #4 transferred with a sit-to-stand mechanical lift or a full body lift. During an interview on the afternoon of 01/29/15, a restorative therapy aide (#10) stated Resident #4 participated in a range of motion group, but does not ambulate anymore. The aide further stated, "It has been awhile [since Resident #4 ambulated with restorative therapy.]" During an interview on 01/30/15 at 8:39 a.m., a restorative therapy aide (#9) stated Resident #4 does not ambulate anymore. The aide identified it has been over a month since the resident last ambulated. - Review of Resident #6's medical record occurred on all days of survey. After a hospitalization in November 2014, the resident received a course of intravenous (IV) antibiotics through a peripherally inserted central catheter (PICC line). The record identified the PICC line was discontinued on 12/23/2014. Review of Resident #6's current care plan stated, "The resident is on IV medications R/T [related to] IV Antibiotic Medication . . . Interventions * Monitor IV site right upper arm and document as appropriate. PICC dressing to be changes [sic] as per protocol . . . " - Review of Resident #2's medical record occurred on January 26-29, 2015. Diagnoses included dementia and generalized pain. A quarterly MDS (Minimum Data Set), dated	F 280		

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 _____	01/29/2015

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 280	Continued From page 4 01/01/15, identified the resident required limited assistance from one person for ambulation and experienced falls without injury since the last MDS. Progress notes showed Resident #2 fell on 10/05/14 and 10/15/14 without injuries. A facility form titled "Fall Risk Data Collection," dated 10/25/14, identified Resident #2 as a medium fall risk. Observation on 01/26/15 at 4:47 p.m., showed Resident #2 stood up from a chair in the television/chapel area, took a moment to get her balance, took one step, paused to gain her balance, took another step, and paused to gain her balance. Resident #2 continued to walk in this manner until she went out the door and into the area by the nurse's station. Resident #2's medical record failed to include a care plan to address falls and interventions to decrease the risk of falls. During an interview on the morning of 01/29/15, an administrative nursing staff member (#1) agreed falls should have been care planned if the MDS identified Resident #2 experienced falls.	F 280		
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.	F 323	F 323 1. Transfers involving resident #1 will utilize a gait belt at all times, per the care plan. 2. All residents needing a gait belt during transfer are to be re-evaluated. Care plans will be updated as needed. 3. A mandatory in-service training related to care plans and the importance of safety in transfers will be performed by the Director of Nursing Services and Nurse Managers and will be attended by all nursing staff.	3/5/15

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 _____	01/29/2015

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 323	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, record review, procedure review, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 2 sampled residents (Resident #1) care planned for using a gait belt with transfers. Failure to use the gait belt during transfers placed the resident at risk for injury and/or accidents. Findings include: Review of the facility procedure titled "Gait (Transfer) Belt" occurred on 01/29/15. This procedure, dated October 2013, stated, "Purpose: To safely transfer or ambulate resident . . . To avoid injury to both resident and staff member. Note: Gait belts used unless medically contraindicated. Procedure: . . . 2. Place belt around resident's waist over clothing. . . . 6. Transfer or ambulate resident and remove belt. 7. Do not use the pants/slacks belt as a gait (transfer) belt. . . ." - Review of Resident #1's medical record occurred on January 26-29, 2015. Diagnoses included history of fall, generalized pain, and shortness of breath. An annual Minimum Data Set, dated 12/06/14, identified the resident required extensive assistance of one staff member for transfers. The current care plan stated, ". . . Focus . . . ADL [activities of daily living] self care performance deficit . . . Interventions . . . Transfer: Resident requires two staff using a gait belt for transfers. . . . Transfers: Resident requires weight bearing support two staff members with resident wearing a gait belt to transfer. . . ."	F 323	4. A gait belt transfer audit will be done weekly for the duration of one month, then monthly for the duration of six months with all results reviewed by the QAPI Team. This audit will be the responsibility of the Director of Nursing Services or designee. If sufficient compliance is not evident, further training will be scheduled. If continued noncompliance by any staff member occurs, it will be met with disciplinary action on a case-by-case basis. 5. The mandatory in-service performed by the DNS and Nurse Managers will be completed on March 3, 2015. Gait belt transfer audits will begin the week of March 2, 2015.	

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 _____	01/29/2015

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 323	Continued From page 6 Observation on 01/28/15 at 8:35 a.m. showed two CNAs (#13 and #14) assisted Resident #1 with toileting using a gait belt. At the end of care, the CNA (#13) removed the gait belt and wheeled the resident to her bedside. To transfer Resident #1 to sit on the bed, the CNA (#13) directed the resident to grab onto the bed rail and lifted the resident by the back of her pants while holding onto her left arm. The CNA's failed to follow Resident #1's care plan regarding the use of a gait belt while transferring the resident. During an interview on the morning of 01/29/15, an administrative nursing staff member (#1) agreed staff should follow the care plan when transferring Resident #1.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 325	F 325 1. The care plan of resident #3 was updated, as well as their tray card, to reflect Benecalorie 1.5oz and other fortified interventions, as well as to assist with eating. Nursing and dietary staff will provide encouragement and prompting to increase meal consumption. Dietary and nursing staff will monitor amount of fortified interventions accepted. In regards to resident #1, nursing and dietary staff will provide encouragement and prompting, as well as assist with meals, to increase meal consumption. Dietary staff will monitor the amount of fortified interventions. Resident #1 supplement times will be "in between meals" and reflected in the care plan as such. The evening snack for resident #1 will be given with the HS medication pass and will be reflected in the care plan as such.	3/5/15

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 _____	01/29/2015

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 325	Continued From page 7 facility policy, and staff interview, the facility failed to implement and monitor interventions to prevent weight loss and maintain nutritional status for 2 of 5 sampled residents (Resident #1 and #3) with weight loss. Failure to initiate timely and effective interventions, re-evaluate and modify the interventions as needed, and consistently implement existing interventions resulted in severe weight loss for Resident #1 and #3. Findings include: Review of the facility policy titled "Fortified Foods" occurred on 01/29/15. This policy, dated February 2013, stated, ". . . Fortified foods are menu items and snacks that are enhanced through the addition of naturally concentrated ingredients while maintaining the identity of the item. . . . It is a best practice to consider fortifying foods of choice before implementing medical nutritional supplements. . . . When more complete evaluation of the acceptance of individual fortified foods is needed, the resident's intake at meals will be evaluated more closely for a short period of time . . . Adjustments will be made to the resident's menu plan as needed. . . . The DDS [director of dietary services] will observe routinely on meal rounds and review meal intake records to validate intake. . . ." Review of the facility policy titled "Monitoring Residents with Impaired Nutrition and Nutritional Risk" occurred on 01/29/15. This policy, dated February 2013, stated, ". . . The DDS or designee will review residents weights monthly or more often to identify residents with significant weight loss/gain (5 percent in 30 days, 7.5 percent in 90 days, or 10 percent in 180 days) or insidious weight loss or gain. Insidious weight loss or gain	F 325	2. Weekly weights are taken on each resident and will be assessed by the Director of Nursing Services and Director of Dietary Services weekly for significant change. Any significant change in weight will be monitored closely by the consulting dietician and interventions will be put in place. 3. If a fortified diet is ordered for any resident, their intake of fortified foods will be closely monitored by both dietary and nursing staff. If a fortified intervention is not effective, an alternate fortified intervention will be put in place. Visits from the consulting dietician will be increased from bi-monthly to weekly beginning on March 5, 2015 for the duration of two months. In addition, a mandatory in-service training related to dietary documentation and nutritional risk will be performed by the Director of Nursing Services, Director of Dietary Services and the consulting dietician and will be attended by all dietary staff. 4. A dietary audit will be done weekly for the duration of one month, then monthly for the duration of six months with all results reviewed by the QAPI Team. This audit will be the responsibility of the Director of Nursing Services and the Director of Dietary Services or designees. If sufficient compliance is not evident, further training will be scheduled. If continued noncompliance by any staff member occurs, it will be met with disciplinary action on a case-by-case basis.	

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 _____	01/29/2015

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 325	Continued From page 8 refers to a gradual, unintended, progressive weight loss or gain over time. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included a history of nutritional deficiency, esophageal reflux, constipation, and a history of weight loss. The current Minimum Data Set (MDS), dated 12/30/14, identified severely impaired cognition, eats independently with set up help only, and a non-prescribed weight loss. Resident #3's current care plan stated, ". . . Focus . . . The resident has unplanned weight loss. . . . Interventions . . . Give resident fortified menu. Receives super cereal, fortified milk, and house supplement. Daughter brings Ensure drinks for resident . . ." Current physician's orders included: "Regular diet, Regular texture, Regular fluid consistency, Calorie/Protein enhanced" and "House Supplement two times a day for weight maintenance 3 oz [ounces] bid [twice per day] between meals [increased from 2 oz bid on 01/26/15]. Review of the Medication Administration Record confirmed Resident #3 received the house supplement BID. Review of Resident #3's weights showed the following weight loss: *06/02/14: 152 pounds (lbs) *06/09/14: 152 lbs *07/07/14: 151 lbs *08/04/14: 152 lbs *09/08/14: 145 lbs *10/06/14: 143 lbs	F 325	5. The mandatory in-service performed by the Director of Nursing Services, the Director of Dietary Services and the consulting dietician will be completed on March 5, 2015. Dietary audits related to documentation and nutritional risk, including fortified food intake documentation, will begin the week of March 2, 2015.	

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 _____	01/29/2015

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 325	Continued From page 9 *11/17/14: 140 lbs *12/01/14: 136 lbs (This weight triggered a 10.5% weight loss warning from the computer) *12/22/14: 136 lbs (This weight triggered a 10.5% weight loss warning) *12/29/14: 136 lbs (This weight was identified on the 12/30/14 MDS and triggered a 10.5% weight loss warning) *01/05/15: 135 lbs (This weight triggered an 11.2% weight loss warning) *01/12/15: 132 lbs (This weight triggered a 13.2% weight loss warning) *01/19/15: 133 lbs (This weight triggered an 11.9% weight loss warning) *01/26/15: 128 lbs (This weight triggered a 15.8% weight loss warning) *The weights showed a 23 pound weight loss (15%) over six months (July-January). Resident #3's Dietary notes identified the following: *08/19/14: ". . . Weight 149# [pounds] (8/18/14). Meal intakes over the past week averaged 47%. Res. [resident] has edema noted to lower extremities and is receiving wraps to control edema. [nurses' notes identified the development of pedal edema following the resident's fall on 06/28/14] . . . Continues to receive Med Pass 2.0 [house supplement] 2 oz BID. . . ." *09/30/14: ". . . Weight 145# (9/29/14) . . . Meal intakes average 55% over the past week. Continues to have wound to (L) [left] lower leg which is healing. Receives Med Pass 2.0 2 oz BID to promote healing and weight maintenance . . ." *10/08/14: ". . . Receives regular diet with calorie and protein enhanced with supplements twice daily r/t [related to] past weight loss and healing. Current weight is 145# which is down 7# for this	F 325		

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 _____	01/29/2015

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 325	Continued From page 10	F 325		

quarter but same weight as one year ago. During this time had injury to leg and increased edema which is resolving. Meal acceptance varies but averages just over 50%. . . ."
*10/28/14: ". . . Weight 141# (10/27/14) . . . Has had some weight loss which is r/t decreased edema. Meal intakes average 58% over the past week. . . . Will continue to monitor weights. . . ."
*11/18/14: ". . . Weight 140# (11/17/14) . . . Meal intakes averaged 52% over the past week which is typical for the resident. . . . ."
*12/02/14: ". . . Weight 136# (12/01/14). . . . Meal intakes over the past week averaged 46%. Res. continues to receive Med Pass 2.0 2oz BID. She recently received OT [occupational therapy] for edema management which likely contributed to the weight loss [a physician's order identified an order, dated 10/10/14, for compression stockings]. Will add super cereal at breakfast and fortified milk with meals to promote weight maintenance. Will continue to monitor. . . ."
*12/16/14: ". . . Weight 136# (12/15/14) . . . Meal intakes averaged 49% over the past week. . . ."
*01/05/15: ". . . Meal acceptance averages 40-55%. Current weight 136# showing significant loss of 16# over past 6 months. . . . Dietician recommended super cereal, fortified milk, and continues to receive house supplement 2oz bid. . . ."
*01/13/15: ". . . Current weight 132# (1/12/15). . . . Meal intakes averaged 39% over the past week. Weight loss and decreased appetite are likely r/t current illness. Res has an URI [upper respiratory infection] and is receiving A/B [antibiotic] treatment [a nurse's note identified the completion of antibiotics on 01/13/15]. . . ."
*01/27/15: ". . . Weight 128# (1/26/15). . . . Meal intakes over the past week averaged 34%. Res had a recent URI which likely contributed to some

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 _____	01/29/2015

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 325	Continued From page 11 of the weight loss. Previous weight loss is r/t to [sic] decreased edema. Med Pass 2.0 was increased to 3 oz BID 1/26/15. She continues to receive fortified cereal at breakfast and fortified milk with meals. Suggest also to offer Benecalorie 1.5 oz daily at breakfast as her intakes tend to be better at breakfast. . . ." Review of Resident #3's tray card (used by dietary staff to identify types of diets, beverages, likes, and dislikes) identified a regular fortified diet, a small glass (4 oz) of fortified milk at all three meals, and "branflakes" at breakfast. During an interview on 01/29/15 at 9:50 a.m., a supervisory dietary staff member (#3) stated "super cereal" is hot cereal topped with whole milk, powdered milk, butter, and brown sugar. She stated "fortified milk" is whole milk with powdered milk mixed in, and the facility does not have a specific menu for "fortified" foods. She stated Resident #3 does not eat hot cereal, and residents who do not like the "super cereal" should get an additional glass of fortified milk to pour on their cereal. Observation on 01/27/15 at 9:28 a.m. showed Resident #3 in the dining room eating breakfast which consisted of scrambled eggs, toast, prune juice, coffee, and a small glass of milk (approximately 4 oz). The resident requested a bowl of cereal from an unidentified certified nursing assistant (CNA). Resident #3 then poured the milk on her cereal. Observation showed the resident consumed her cereal but left most of the milk in the cereal bowl. Observation on 01/27/15 at 11:47 a.m. showed Resident #3 in the dining room eating lunch which	F 325		

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 _____	01/29/2015

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 325	Continued From page 12	F 325		

consisted of a chicken breast, mashed potatoes and gravy, cooked carrots, bread with butter, a small glass of milk, and coffee. Observation showed the resident attempted to cut her chicken breast, but was unable. At the end of the meal, observation showed multiple knife marks on the chicken breast, but the resident did not consume any. The staff failed to offer assistance to Resident #3 throughout the meal. The resident consumed approximately half of her potatoes, half of her bread, no carrots, and no chicken. Resident #3 brought half a glass of her milk out of the dining room with her to "drink later."

Observation on 01/27/15 5:34 p.m. showed a dietary aide (#11) poured Resident #3 a small glass of milk from a carton located inside a small fridge. The carton identified 2% milk. The dietary aide confirmed Resident #3 received 2% milk.

Observation on 01/28/15 at 9:27 a.m. showed Resident #3 in the dining room eating breakfast, which consisted of pancakes, sausage, bran flakes, prune juice, a small glass of fortified milk, and coffee. Observation showed staff did not add Benecalorie to the foods/beverages. The resident poured the fortified milk over her cereal and consumed approximately 25% of her pancake, no prune juice, and all of her cereal. Observation showed most of the milk remained in her cereal bowl.

Observation on 01/29/15 at 8:28 a.m. showed Resident #3 in the dining room eating breakfast which consisted of a small glass of fortified milk, bran flakes, a breakfast pastry, coffee, and prune juice. Observation showed staff did not add Benecalorie to foods/beverages. During an interview, a dietary cook (#12) stated he did not

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 _____	01/29/2015

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 325	Continued From page 13 give Resident #3 any Benecalorie because there was not an order for it. He identified two other residents as the "only 2 residents on it." During an interview on 01/29/15 at 9:50 a.m., a supervisory dietary staff member (#3) stated staff should give Resident #3 two glasses of fortified milk at breakfast, one for the cereal and one to drink. Review of the drink lists (used by staff to identify which drinks to serve to residents) identified "2% milk" next to Resident #3's name at both noon and evening meals. Next to her name on the evening meal drink list, a supervisory dietary staff member (#3) wrote fortified milk in marker. The staff member stated she added the notation "not more than two weeks ago," although record review identified the initiation of fortified milk on 12/02/14. Although Resident #3 experienced edema following a fall with a fractured foot, record review identified stable weights prior to and shortly after the fall and a gradual, unintended weight loss of 15% over a period of six months. Staff failed to implement additional interventions in a timely and effective manner, evaluate the effectiveness of existing interventions (i.e. fortified menus and super cereal) and modify interventions as needed, provide set up assistance at meals (by cutting the resident's chicken), and ensure the consistent implementation of weight loss interventions (additional fortified milk at breakfast, fortified milk [not 2%] at all meals, Benecalorie at breakfast). These failures resulted in Resident #3's severe, avoidable weight loss. - Review of Resident #1's medical record	F 325		

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 _____	01/29/2015

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 325	Continued From page 14	F 325		

occurred on January 26-29, 2015. The facility completed an annual MDS on 12/06/14. The nutritional status Care Area Assessment Summary attached to this MDS identified the facility provided Resident #1 a regular diet with calorie and protein enhancement due to low body weight.

Resident #1's current care plan for nutrition stated, "Focus . . . The resident has nutritional problem or potential nutritional problem R/T [related to] lack of appetite E/B [evidenced by] history of weight loss. . . . Interventions . . . Give resident fortified menu with calorie and protein enhanced. Also received house supplement as ordered. . . ."

Resident #1's "Weights and Vitals Summary" sheet identified her weight on 11/14/14 as 91 pounds, and on 12/12/14 as 89 pounds. Her weight on 01/23/15 was 88 pounds and the computer triggered a warning of a significant weight change (loss). Resident #1 weighed 95 pounds on 12/26/14 a loss of 7.4% in 30 days.

Nutritional Status progress notes stated:
* 1/13/2015, 11:21 a.m., "Weight 86# (1/9/15). . . . Meal intakes average 56%. Weight is back down this week d/t [due to] recent URI . . . Continues to receive fortified cereal with breakfast, fortified milk with meals, and House Supplement 3 oz. TID [three times a day] between meals to promote nutritional addequacy [sic] and weight maintenance. Will continue to monitor."
* 1/27/2015, 3:45 p.m., "Weight back up to 88# (1/23/15). . . . Meal intakes averaged 66% over the past week which is an improvement. . . . Continues to receive fortified cereal with

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 _____	01/29/2015

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 325	Continued From page 15	F 325		

breakfast, fortified milk with meals, and House Supplement 3 oz. TID between meals to promote nutritional addequacy [sic] and weight maintenance. Will continue to monitor."

The Medication Administration Record (MAR) showed staff provided Resident #1 the house supplement at 8:00 a.m., 12:00 p.m., and 8:00 p.m. The 8:00 a.m. and 12:00 p.m. are with breakfast and the noon meal, not between meals as ordered. The evening snack documentation for the month of January 2015 showed facility staff did not provide an evening snack due to Resident #1 being asleep.

Observations showed the following:
* No fortified milk provided with evening meals January 26-28, 2015.
* The nurse (#7) provided Resident #1 with her supplement prior to breakfast. The nurse (#7) encouraged Resident #1 by putting the supplement closer to the resident and stated, "I know how much you love it." Resident #1 replied, "No I don't"
* At the noon meal, on 01/28/15 at 11:55 p.m. staff placed the milk out of Resident #1 reach. Observation at 12:55 showed the milk moved closer to Resident #1, and she consumed half her milk.

During an interview on 01/27/15 at 5:30 p.m., an administrative nursing staff member (#6) identified the nurses do not document how much house supplement Resident #1 consumes. This nurse (#6) identified meals are recorded by totals of food and beverage consumed. The facility's intake traking is about food and fluids in general. They do not track how much of Resident #1's intake is specifically fortified food or beverages.

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 _____	01/29/2015

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 325	Continued From page 16 The facility failed to provide supplements between meals and provide enhanced milk with each meal. Failure to document the amount of the supplements and/or enhanced foods provided to Resident #1 did not allow dietary staff to determine if the interventions in place were effective or needed to be changed. These failures may contribute to the fluctuating weight experienced by Resident #1.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F 329 1. In regards to resident #1, and initial AIMS assessment was not done in a timely manner, however, the AIMS assessment will continue to be done every six months for this resident. Resident #1 care plan was updated to include psychopharmacological medication monitoring for side effects and adverse consequences. Staff will be instructed to document the behaviors of resident #5, utilize non-pharmacological interventions and, if given, document the effectiveness of the antipsychotic medication given. It is of note that Alprazolam is not given often to this resident. Resident #5 care plan was updated to include psychopharmacological medication monitoring for side effects and adverse consequences.	3/5/15

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 _____	01/29/2015

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 APPROPP' DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on record review and facility policy review, the facility failed to ensure 2 of 4 sampled residents (Resident #1 and #5) who received psychoactive medications did not receive unnecessary medications. Failure to assess and monitor for potential side effects and attempt non-pharmacological interventions prior to administration of psychoactive medications may result in residents experiencing adverse consequences and receiving unnecessary medications. Findings include: Review of the facility procedure titled, "Psychopharmacological Medications and Sedative/Hypnotics" occurred on 01/29/15. This policy, revised June 2014, stated, ". . . Procedure: Non-Emergency Administration 1. Before administration of non-emergency psychopharmacological and/or sedative/hypnotics, the following must be completed: b. The behavior committee and/or care plan team will ensure the care plan is updated. This update will reflect non-pharmacological interventions to be used. . . . 5. If the physician prescribes an antipsychotic for the resident, a registered nurse must complete the . . . Initial Antipsychotic Medication Assessment . . . and the . . . Abnormal Involuntary Movement Scale [AIMS] . . . 7. While the use of prn psychopharmacological and/or sedative/hypnotics is not encouraged . . . It is important to initiate other care plan interventions prior to the use of prn (as needed) psychopharmacological and/or sedative/hypnotics	F 329	2. Non-pharmacological interventions will be care-planned that are resident-specific and attempted prior to administration of antipsychotic medication for any resident. In addition, for all residents utilizing antipsychotic medication, the behaviors will be documented prior to receiving an antipsychotic order and all attempts to lessen and/or discontinue the use of antipsychotic medications will be utilized. The effectiveness of an antipsychotic, if given, will be documented, as well. The AIMS assessment will be applied to each resident prior to beginning the administration of an antipsychotic and every six months following and a pharmacy review will be done monthly. 3. In addition, a mandatory in-service training related to non-pharmacological interventions will be performed by the Director of Nursing Services and Nurse Managers and will be attended by all nursing staff. 4. A nursing audit will be done weekly for the duration of one month, then monthly for the duration of six months with all results reviewed by the QAPI Team. This audit will be the responsibility of the Director of Nursing Services or designee. If sufficient compliance is not evident, further training will be scheduled. If continued noncompliance by any staff member occurs, it will be met with disciplinary action on a case-by-case basis.	

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 _____	01/29/2015

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 329	Continued From page 18 . . . " - Review of Resident #1's medical record occurred on January 26-29, 2015. Diagnoses included impaired cognitive function/dementia, depression, and delusional disorder. An annual Minimum Data Set (MDS), dated 12/16/14, a quarterly MDS, dated 09/19/14, and an admission MDS, dated 12/24/13, all identified severe cognitive impairment, and no behavioral symptoms. Resident #1's primary physician wrote an order for a psychiatric evaluation on 06/04/14. Resident #1 first visited the psychiatrist on 07/07/14. The psychiatrist diagnosed the resident with depression and delusional disorder. Review of the current physician's orders identified Resident #1 received Risperdal (an antipsychotic) 0.125 milligrams (mg) orally at bedtime, ordered 08/11/14. Resident #1's medical record lacked an "Initial Antipsychotic Medication Assessment" and an AIMS assessment prior to the administration of the antipsychotic medication Risperdal as per facility policy. Facility staff completed Resident #1's AIMS on 09/08/14, 28 days later. The facility failed to consistently utilize non-pharmacological interventions to assist Resident #1 to control her behaviors. Failure to complete facility required assessments, consistently identify/document the actual behavior exhibited may have resulted in the initiation of an unnecessary antipsychotic medication for Resident #1.	F 329	5. The mandatory in-service performed by the Director of Nursing Services and Nurse Managers will be completed on March 3, 2015. Nursing audits related to "unnecessary drugs" will begin the week of March 2, 2015.	

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 _____	01/29/2015

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 329	Continued From page 19 - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, unspecified psychosis and paranoid state, and pain. Medications included alprazolam (an antianxiety medication) 0.125 mg every 6 hours PRN. Resident #5's quarterly MDS, dated 11/06/14, and an annual MDS, dated 05/06/14, identified severely impaired cognition and wandered four to six days, but less than daily. The current care plan stated, "FOCUS: the resident has a behavior symptom R/T [related to] Alzheimer's Disease, unspecified paranoid state, unspecified psychosis E/B [evidenced by] gets angry, may swear or hit at staff . . . Interventions: . . . BEHAVIOR - NON-PHARMACOLOGICAL: Attempt non-pharmacological interventions; go for a walk, snack, coffee (hot chocolate), offer to help find [names of dolls], 1-1 visit . . . " Review of Resident #5's nurses' notes and medication administration record (MAR) from October 1, 2014 through January 23, 2015 identified facility staff administered alprazolam nine times for increased agitation/anxiety without attempting non-pharmacological interventions prior to the administration of the alprazolam. The facility failed to assess possible causes or factors that may have contributed to the residents increased agitation/anxiety and to implement non-pharmacological interventions as stated in the care plan, prior to administering PRN antianxiety medication.	F 329		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364		

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 _____	01/29/2015

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 364	Continued From page 20 Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, group interview, and review of facility policy/procedure, the facility failed to ensure the service of palatable food during 1 of 3 meals observed (test tray during the noon meal on 11/27/15). Failure to ensure the palatability of foods and serve cold foods at the correct temperature may result in decreased meal intakes. Findings include: Review of the facility policy/procedure titled "Food Temperatures" occurred on 01/29/15. This policy/procedure, dated February 2013, stated, " . . . Cold foods will be held at or lower than 41 degrees and served promptly after being removed from the refrigerator. . . ." - Observation during breakfast on 01/27/15 at 7:40 a.m., showed two trays containing milk, milk products, and various juices on the counter at the serving window. The beverages on the trays were not on ice. Two juice beverages from these trays remained at the serving window when last observed at 9:30 a.m., nearly two hours later. - During the resident group interview on 01/27/2015 at 10:00 a.m., the residents present	F 364	F 364 1. Resident #7 is prompted and cued to eat when each meal is served. In addition, dietary and nursing staff offer resident #7 a new meal or brings an additional food item, if resident #7 indicates the food is cold. 2. Temperatures are taken on all resident beverages and meals at each meal. 3. Meals dished to residents, if staying in their rooms, are served with a warming cover immediately prior to its delivery to the room. No meal is to be placed on a plate until the resident is sitting at the dining table and ready to eat their meal. In addition, visits from the consulting dietician will be increased from bi-monthly to weekly beginning on March 5, 2015 for the duration of two months. Furthermore, a mandatory in-service training related to food temperatures will be performed by the Director of Dietary Services and the consulting dietician and will be attended by all dietary staff. 4. A temperature will be taken once a week on one meal for three months, at rotating times, with all results reviewed by the QAPI Team. This audit is the responsibility of the Director of Dietary Services. If sufficient compliance is not evident, further training will be scheduled. If continued noncompliance by any staff member occurs, it will be met with disciplinary action on a case-by-case basis.	3/5/15

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 _____	01/29/2015

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 364	Continued From page 21 at the interview discussed the food and food service at the facility. Resident A stated, "the food is sometimes cold." Resident B stated it could be warmer. - Observation of tray line for the noon meal on 01/27/15 began at 11:32 a.m. Observation showed beverages placed on the tables for residents. A dietary staff member (#5) obtained beverages for a resident who requested a room tray from the table and placed them on a tray to take to the resident. The surveyor requested the milk for this resident for a test tray and staff poured a fresh glass of milk for the resident. After dishing the last resident tray, the cook (#3) prepared a test tray at 12:22 p.m. The test tray showed the following temperatures: The milk from the dining room table - 70 degrees; Carrots and mashed potatoes - 120 degrees. The survey team sampled food and milk from the test tray and agreed the potatoes and carrots were not hot, and the milk tasted warm. Failure to serve cold and hot foods at palatable temperatures may result in decreased intakes and/or weight loss. - Review of Resident #7's medical record occurred on January 28-29, 2015. Diagnoses included unspecified nutritional deficiency and a history of weight loss. The current Minimum Data Set (MDS), dated 12/24/14, identified intact cognition. During an interview on 01/29/15 at 9:10 a.m., Resident #7 stated, "There is always something cold on the plate," and identified specific	F 364	5. The mandatory in-service performed by the Director of Dietary Services and the consulting dietician will be completed on March 5, 2015. Dietary audits related to food temperatures will begin the week of March 2, 2015.	

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 _____	01/29/2015

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 364	Continued From page 22 concerns with "vegetables," "carrots," "fish," and "mashed potatoes." The resident further stated, "Mashed potatoes should be hot."	F 364		
F 371 SS=B	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 and staff interview, the facility failed to ensure sanitary storage of foods in 1 of 1 kitchen and 2 of 2 medication storage areas (medication room and medication cart). Failure to ensure staff did not store scoops in food containers placed residents consuming foods and beverages prepared from those containers at risk of contamination. Findings include: - During the initial kitchen tour on 01/26/15 at 1:20 p.m., observation showed seven containers of ready to eat cereals with bowls stored in the cereal. - Observation during breakfast on 01/27/15 showed the cook (#3) reached into a container of dry cereal and used the bowl stored in the	F 371	F 371 1. Scoops were removed on January 30, 2015 from the cereal, Benefiber, ProPass, and Fiber Basics containers. 2. Scoops are no longer to be stored in any container of cereal, Benefiber, ProPass, Fiber Basics or any other product to be served/administered to residents. 3. Large, pourable canisters with lids will be used for serving cereal. The Benefiber, ProPass, and Fiber Basics are to be used with a scoop that is stored in a sealed plastic bag outside of the canisters. In addition, visits from the consulting dietician will be increased from bi-monthly to weekly beginning on March 5, 2015 for the duration of two months. Furthermore, a mandatory in-service training related to scoops will be performed by the Director of Dietary Services and the consulting dietician and will be attended by all dietary staff. 4. A dietary audit will be done twice weekly for the duration of one month, then monthly for the duration of six months with all results reviewed by the QAPI Team. This audit will be the responsibility of the Director of Dietary Services or designee. If sufficient compliance is not evident, further training will be scheduled. If continued noncompliance by any staff member occurs, it will be met with disciplinary action on a case-by-case basis.	3/5/15

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 _____	01/29/2015

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 371	Continued From page 23 container to scoop cereal into a different bowl for serving. The cook (#3) repeated this process for each resident receiving dry cereal. - Observation of cereal containers on 01/27/15 at 11:32 a.m. and 01/28/15 at 7:30 a.m., showed bowls used to scoop the cereal stored in the containers of dry cereal. - A tour of the kitchen occurred on 01/28/15 at 4:10 p.m. with two administrative dietary staff members (#3 and #4). Observation showed dietary staff stored bowls in seven canisters of dry cereal; and scoops in a container of cinnamon sugar and a container of Benefiber. - Observation of medication pass occurred on 01/27/15 at 5:35 p.m. A certified medication aide (CMA) (#8) opened a container of ProPass (a powdered protein supplement) and used a scoop stored inside the container to measure the supplement into a cup. The CMA then put the scoop back inside the container of ProPass. - Observation in the medication room on 01/28/15 at 4:35 p.m. showed a container of Fiber Basics (a powdered fiber supplement) with a scoop stored inside. During an interview on the morning of 01/29/15, an administrative nurse (#1) agreed staff should not store scoops inside supplement containers.	F 371	5. The mandatory in-service performed by the Director of Dietary Services and the consulting dietician will be completed on March 5, 2015. Dietary audits related to scoops will begin the week of March 2, 2015.	