STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	03/02/2016

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 02/29/16 and completed on 03/02/16, the sample included two (2) resident for complete review, eight (8) residents for focused review, and one (1) closed record for review. The sample included five (5) additional residents to verify specific concerns during the survey.	F 000		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, group interview, and staff interview, the facility failed to provide ongoing, individualized, and meaningful activities on the weekends for 4 of 5 residents (Resident A, B, C, and D) who attended the group interview, and for 1 of 3 individual residents (Resident F) interviewed. Failure to implement an individualized and meaningful activity program on weekends may negatively affect the resident's psychosocial well-being. Findings include: - The group interview occurred on 03/01/16 at 9:30 a.m. with Resident A, B, C, D, and E in attendance. When asked about the activity program and if they have enough to do, Resident	F 248	1) One more activity will be added on each weekend day. This activity, along with all activities, will include resident interests and also enhance the resident□s highest practicable level of physical, mental and psychosocial wellbeing. For residents A, B, C, D, E, and F, the Activities Director will individually interview and assess their current activity interests and preferences and modify as needed. 2) All residents have the potential to be affected. Any and all suggestions to modify the activities the facility currently has will be considered and followed up on by the Activities Director. 3) The activity interests will be updated	4/21/16

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

Electronically Signed | 03/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	03/02/2016

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 248	Continued From page 1 A, B, C, and D stated the weekdays are fine but there is "nothing on weekends." - Review of Resident F's medical record occurred on all days of survey. The resident's current MDS, dated 12/05/15, identified intact cognition. During an interview on 03/01/16 at 4:02 p.m., Resident F stated there is "not enough to do" regarding activities, "especially weekends." The resident identified "once in awhile, a guy comes in and plays guitar during coffee time on Saturdays," but otherwise, there is "absolutely nothing" to do on the weekends except the 2:30 p.m. coffee time. Review of the facility's activity calendar for February 2016 showed the following weekend activities: *February 6th: Devotions, Rising Stars (exercise), 1 to 1 visits, and coffee time (outside music provided) *February 7th: Church services (on TV), devotions, coffee time, and Pastor visit (did not come) *February 13th: Devotions, Rising Stars 1 to 1 visits, coffee time *February 14th: Church services (on TV), devotions, coffee time *February 20th: Devotions, Rising Stars, 1 to 1 visits, and coffee time (outside music provided) *February 21st: Church services (on TV), devotions, Coffee time, Pastor visit (did not come) *February 27th: Devotions, Rising Stars, coffee time and open house for birthdays *February 28th: Church services (on TV), devotions, coffee time.	F 248	quarterly instead of annually for each resident. We will continue to ask the group at resident council, What other activities would you like to do? and/or What current activities do you enjoy/not enjoy? Continue with routine activities and, as stated above, supplement each weekend day with one more activity. One to ones will be removed from weekend activities, replaced by an activity with a larger audience. Staff education at the April 21, 2016 All Staff Meeting will include the importance of altering and modifying activities according to the needs and interests of the residents. The education will also stress the importance of following up on resident concerns regarding activities and regarding all concerns. 4) The Activities Director or designee will audit, each Monday, how well the resident□s enjoyed the weekend activities on a scale of 1 to 10. This will be asked, at random, to 5 residents. The question will read as follows, How satisfied were you with this weekend□s activities? This audit will be performed weekly for one month, then bimonthly for one month, and then monthly for four months. Progress will be tracked and discussed at QA meetings. 5) The above corrective action will be completed no later than April 21, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	03/02/2016

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 248	Continued From page 2 Additional activities included the following: *February 7th: "Read a story" *February 13th: polished five female resident's nails (Resident E and F attended) *February 14th: "passed out valentines" *February 21st: "[name] came. . . played his guitar." *February 28th: polished three female resident's nails (Resident A attended) During an interview on the afternoon of 03/02/16, an activity staff member (#7) stated she or another staff member work from 10:45 a.m. to 3:30 p.m. on the weekends. Her weekend routine included: devotions shortly before lunch; escort residents to lunch; some charting; "maybe some nail care;" some more charting; escort residents to and from coffee time in the afternoon; and then more charting.	F 248		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 2 of 2 sampled residents (Resident #1 and #10) who exhibited a change in condition. Failure to report a change in urine color/odor and emesis (vomit) (Resident #1) and wheezing (Resident #10) to the charge nurse may result in worsened symptoms and a delay in necessary	F 281	1) Resident #1□s care plan was altered to state, Report unusual observations and conditions such as cloudiness, strong odor and decreased output. Also added to Resident #1□s care plan: Monitor amount, color, consistency, odor and frequency, duration of emesis and report to Charge Nurse. A scheduled task labeled emesis was added so direct care	4/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	03/02/2016

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 281	Continued From page 3 treatment. Findings include: Mary E. Stassi, "Basic Nurse Assisting," 2005, St. Louis, Missouri, page 56, stated, "How to Observe and Report Information: . . . Because you spend more time with the patient than any other member of the health care team, your observations are very important. . . . You will tell the nurse about your findings. . . . You should report changes in the patient's condition or abnormal signs and symptoms immediately. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included urinary retention and an indwelling urinary catheter. Observations of Resident #1 included the following: * On 02/29/16 at 5:43 p.m., the certified nursing assistant (CNA) (#12) emptied the resident's catheter bag into a graduate cylinder and identified the urine as "pretty cloudy." The CNA failed to inform the nurse. * On 03/01/16 at 12:45 p.m., the CNA (#14) emptied the resident's catheter bag into a graduate cylinder and identified the urine as "very cloudy and very strong [odor]." The CNA failed to inform the nurse. * On 03/01/16 at 2:00 p.m., the CNA (#14) entered the resident's room. The resident stated he felt ill and confused today and began to cough and vomited. The CNA (#14) cleaned the emesis off the resident's face and pillowcase. A nurse (#8) entered the room and assisted the CNA (#14) to transfer the resident from bed to a	F 281	staff will chart on each shift small, medium, large or n/a. In regards to Resident #10, a scheduled task was added through the care plan which stated, Observe and report to nurse any increases or changes in wheezing related to shortness of breath. 2) All residents have the potential to be affected. The facility will continue to update care plans with change in condition for all residents. DNS or designee will stress the importance the end of shift, 24-hour reports, and walkie talkies for increased communication to charge nurse. Charge nurse will remind staff at each shift report the importance of reporting, immediately, any change of condition. 3) On April 21, 2016, our facility will hold our quarterly mandatory All Staff Meeting, wherein we will educate all staff regarding their obligation to report immediately to nurse including but not limited to: decreased output, emesis, change in condition, increased weakness, unusual or severe behavior, and/or skin integrity issues. 4) The DNS or designee will perform random observations of one care on three separate and random residents five times per week for two weeks. After that point, the audits will be performed weekly for two weeks, then monthly for five months. Effectiveness will be measured by the amount of interventions made in response to a change in condition. In addition to this, this report needs to be documented properly in the resident□s EMR. Progress	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	03/02/2016

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 281	Continued From page 4 wheelchair. The CNA (#14) failed to inform the nurse (#8) of Resident #1's concerns and emesis. - Review of Resident #10 medical record occurred on 03/02/16. Diagnoses included dementia and dyspnea (shortness of breath). Observation on 03/02/16 at 10:00 a.m. showed two CNAs (#2 and #5) utilized a full body mechanical lift and transferred Resident #10 from a wheelchair to the bed. The resident could be heard wheezing. The CNA (#5) stated Resident #10 always has some wheezing but it has been "worse for a week or two" and "especially bad today." The CNA (#5) stated she would inform the nurse and see if the resident could get a nebulizer treatment. During an interview on 03/02/16 at 1:45 p.m., the nurse (#10) stated she had not been informed of Resident #10's wheezing and had not administered a nebulizer treatment.	F 281	will be measured and tracked by the QA Committee. 5) The above corrective action will be completed no later than April 21, 2016.	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide appropriate services to maintain or improve ambulation for 1 of 1 sampled residents (Resident #5) care planned to ambulate to and from meals. Failure	F 311	1) A scheduled task, three times daily, for Resident #5 will read, Ambulate to and from meals. This will ensure that the direct care staff will have to chart on her ambulation or refusal thereof.	4/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	03/02/2016

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 311	Continued From page 5 to ensure Resident #5 receives necessary assistance to maintain or improve ambulation ability may result in an avoidable activities of daily living (ADL) decline. Findings include: Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia, anoxic brain damage, and osteoporosis. The current Minimum Data Set (MDS), dated 12/27/15, identified severe cognitive impairment and extensive assistance from one person for ambulation. The resident's current care plan identified, ". . . The resident has an ADL self care performance deficit R/T [related to] CAD [coronary artery disease] with history of Cardiac Arrest and history of Anoxic Brain Injury E/B [evidenced by] Dementia, and ongoing progression of disease process . . . TRANSFER: Resident requires 1 staff assist with gait belt from bed/toilet/chair to Broda chair. Place in Broda chair after ambulating to and from meals. . . ." Observations during the survey showed the following: *02/29/16 at 5:34 p.m.: Resident #5 sat in her wheelchair in the commons area. A certified nursing assistant (CNA) (#3) approached the resident and asked, "Are you ready to go to the dining room?" Resident #5 replied, "Yes." The CNA brought Resident #5 to the dining room in her wheelchair and failed to offer/attempt ambulation. *03/01/16 at 11:19 a.m.: Resident #5 sat in her wheelchair in the commons area. A CNA (#4) approached the resident and asked, "Can I take you down to the dining room? Are you hungry?"	F 311	2) All residents who are to ambulate with assistance to meals have the potential to be affected. Continue to monitor all residents for restorative and maintenance compliance. The Mobilization Data Assessment will be completed quarterly and also with any change resident□s condition or ability. 3) At the mandatory April 21, 2016 All Staff Meeting, education will be delivered on the importance of restorative and maintenance programs. A physical therapist will provide a 15-minute educational session at that time. In addition, the Restorative Therapy Aide and Case Manager will meet monthly to evaluate the effectiveness and appropriateness of each resident□s current restorative and/or maintenance program. Together, they will ask the following questions: Is the care plan being followed? Can he/she improve? Is this resident still appropriate for this program? Should we increase/decrease or change the program they are currently receiving? and Is the current program effective for this resident? 4) The Rehabilitation Coordinator or designee will perform a charting audit on three residents biweekly for one month on residents who are on an ambulation program. After that point, weekly for one month, and then monthly for four months. Progress will be measured and tracked by the QA Committee. 5) The above corrective action will be completed no later than April 21, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	03/02/2016

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 311	Continued From page 6 Resident #5 replied, "Yes." The CNA brought Resident #5 to the dining room in her wheelchair and failed to offer/attempt ambulation. *03/02/16 at 9:13 a.m.: Resident #5 sat in her wheelchair at the dining room table. A CNA (#5) approached the resident and asked, "Are you ready to hit the road?" Resident #5 replied, "Yes." The CNA took Resident #5 to the commons area in her wheelchair and failed to offer/attempt ambulation. *03/02/16 at 11:28 a.m.: Resident #5 sat in her wheelchair in the commons area. An unidentified CNA approached the resident and stated, "Let's go down and have some lunch." The CNA brought Resident #5 to the dining room in her wheelchair and failed to offer/attempt ambulation. During an interview on 03/02/16 at 2:18 p.m., a supervisory nurse (#1) stated staff should attempt to ambulate Resident #5.	F 311		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to provide assistive devices and supervision necessary to prevent accidents for 1	F 323	1) Resident #12□s table placement will be changed to a table where the foot pedals do not interfere with the structure of the table itself. This measure will	4/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	03/02/2016

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 7 of 1 supplemental resident (Resident #12). Failure to ensure wheelchair foot pedals are in place during staff-assisted transport resulted in pain and may have resulted in foot/ankle injury to Resident #12. Findings include: Mosby's Textbook for Long-Term Care Nursing Assistants, 7th edition, 2015, page 136, stated, ". . . Wheelchair Safety . . . Make sure the person's feet are on the footplates before moving the chair. The person's feet must not touch or drag on the floor when the chair is moving. Never push a person in a wheelchair without feet resting on footplates. . . ." Observation on 03/02/16 at approximately 9:10 a.m. showed a certified nursing assistant (CNA) (#2) transported Resident #12 in a wheelchair from the dining room with the foot pedals on the side of the wheelchair and not in place. As the resident left the dining room, her feet brushed along the floor. The resident stated, "Ouch! Ouch! My foot!" The CNA stopped, placed the foot pedals in front of the wheelchair, and put the resident's feet on them. The CNA stated, "I'm sorry. Are you ok?" The resident replied, "No. It hurts," and indicated her left foot. The certified medication aide (CMA) (#6) directed the CNA to bring the resident to the nurse for an assessment. Review of Resident #12's medical record occurred on the afternoon of 03/02/16. The record lacked evidence of an assessment of Resident #12's foot or documentation of the incident.	F 323	ensure that Resident #12□s feet will always remain on the foot pedals during meals. This will also ensure that, during transport to and from the dining room, her feet will always remain on the foot pedals. 2) All residents have the potential to be affected. Continue to monitor all residents utilizing foot pedals and their potential safety risk. 3) The importance of placing the resident□s feet on the foot pedals, if applicable, will be inserted into New Employee Orientation. This will also be brought up at the mandatory All Staff Meeting on April 21, 2016 wherein all staff will be educated on the importance of placing a resident□s feet on the foot pedals before transport. 4) The Rehabilitation Coordinator or designee will perform a biweekly audit for one month on resident□s transported via wheelchair. After that point, this audit will be conducted weekly for one month, then monthly for four months. This audit will check to ensure foot plates are down and feet are in place during a resident transport with a wheelchair. Progress will be measured and tracked by the QA Committee. 5) The above corrective action will be completed no later than April 21, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	03/02/2016

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 8 During an interview on the afternoon of 03/02/16, a supervisory nurse (#1) identified the staff should have completed an incident report. She stated staff are instructed to transport residents with their feet on the wheelchair foot pedals.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to offer fluids to 1 of 4 sampled residents (Resident #2) dependent on staff for fluid intake. Failure to offer fluids during cares increased Resident #2's risk of dehydration, constipation, and urinary tract infections (UTIs). Findings include: Review of the facility policy titled "HYDRATION OF RESIDENTS" occurred on 03/02/16. This policy, revised February 2016, stated, ". . . PROCEDURE: . . . 7. Fresh water will be available to the residents at bedside unless contraindicated. 8. Residents needing thickened liquids will have appropriate beverages offered between meals. There will be beverages available on the snack cart that is available to residents between meal. . . . 10. Staff members will be trained on the importance of hydration and the signs and symptoms of dehydration. . . ."	F 327	1) Resident #2□s task titled, Intake for fluids outside of meals will now be scheduled, instead of PRN. This will ensure direct care staff chart on his type and amount of fluid consumed each shift. Resident #2□s fluid intake is presently satisfactory. The dehydration CAA is not triggering on his MDS. Resident #2□s fluid intake will continue to be monitored and signs and symptoms of dehydration will be monitored, as well. 2) All residents have the potential to be affected. Continue to monitor residents needing assistance for hydration and/or signs of dehydration. 3) The DNS or designee will review current fluid intake and dehydration and/or risk for dehydration to the Nutritional Risk monthly meeting. Interventions will be implemented as needed. Education on the importance of hydration and the signs of symptoms of	4/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	03/02/2016

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 327	Continued From page 9 Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia and constipation. The quarterly Minimum Data Set (MDS), dated 12/08/15, identified extensive assistance of one or two staff members required for bed mobility and transfers and supervision of one staff member for eating. The resident's care plan stated, "Focus: . . . history of Constipation . . . Increase fiber and fluid intake to provide more bulk in diet . . . Focus: . . . dysphagia . . . Resident requires nectar thickened liquids . . ." An initial tour of the facility occurred on 02/29/16 at 12:45 p.m. Observation showed Resident #2 lying on the bed in his room with his eyes closed and a covered glass of thickened juice on the bedside table, and not within reach of the resident. On 02/29/16 at 4:00 p.m., two certified nursing assistants (CNAs) (#11 and #3) provided personal cares for Resident #2 and assisted him to a wheelchair. Observation showed a covered glass of thickened juice on the bedside table. The CNA (#3) told the resident she "will take you for a snack now" and transported him to the lounge area. The CNAs (#11 and #3) failed to offer Resident #2 fluids in his room before transporting him to the lounge. The CNA (#3) failed to offer the resident a snack or beverage in the lounge area. Observation on 03/01/16 from 8:20 a.m. to 11:25 a.m. showed Resident #2 seated in the lounge area in his wheelchair. Facility staff failed to offer fluids for approximately three hours.	F 327	dehydration will be given at the mandatory April 21, 2016 All Staff Meeting. 4) The DNS or designee will perform random observations of one care on three separate and random residents five times per week for two weeks. After that point, the audits will be performed weekly for two weeks, then monthly for five months. Progress will be measured and tracked by the QA Committee. 5) The above corrective action will be completed no later than April 21, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	03/02/2016

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 327	Continued From page 10 On 03/01/16 at 4:20 p.m., two CNAs (#11 and #13) provided personal cares for Resident #2, assisted him to a wheelchair, and transported him to the lounge area. Observation showed a covered glass of thickened juice on the bedside table. The CNAs failed to offer Resident #2 fluids in his room or in the lounge area. During an interview on the afternoon of 03/02/16, an administrative nurse (#9) stated she expected staff to offer fluids with cares.	F 327		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431		4/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	03/02/2016

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 431	Continued From page 11 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's recommendations, and staff interview, the facility failed to properly store medications in 1 of 1 medication refrigerator. Failure to store medications correctly may decrease the efficacy of the medications. Findings include: Review of the manufacturer's recommendations occurred on 03/02/16 and stated, "Once in use, Novolog Flex Pen must be kept at room temperature . . ." A tour of the medication room occurred on 03/02/16 at 1:50 p.m. with a staff nurse (#10). Observation showed a refrigerator temperature log attached to the refrigerator which stated, ". . . Medications: Refrigerators must be between 36 - 46 [degrees] F [Fahrenheit]." The refrigerator contained 10 assorted insulin vials and two opened Novolog insulin Flex Pens (must store at room temperature). Review of the temperature logs, dated February	F 431	1) Once any insulin pen is open, they are to be left out at room temperature. All licensed personnel will sign a procedure stating this. The temperature of the medication refrigerator should be between 36 and 46 degrees Fahrenheit, per company policy. If the temperature is not within this range, maintenance should be notified immediately and maintenance will direct the course of action. All nursing personnel will sign a procedure stating this. 2) All residents have the potential to be affected. Continue to monitor the proper handling and storage of insulin pens and the temperature of the medication refrigerator. Continue to post signs with instructions of insulin pen storage and refrigerator storage reminders. 3) At the mandatory April 21, 2016 All Staff Meeting, all staff will be reminded of the proper refrigerator temperatures and proper storage of insulin pens. All staff will sign procedures stating this. 4) The DNS or designee will conduct	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	03/02/2016

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 431	Continued From page 12 01 through March 02, 2016, identified on February 01, 02, 05, 06, 07, 08, and 16, and March 02, the temperature registered between 30 and 35 degrees F. During an interview on 03/02/16 at 2:30 p.m., an administrative nurse (#9) stated she expected the mediation refrigerator temperature to be between 36 and 46 degrees F.	F 431	biweekly audits for the duration of one month. After that point, audits will be performed weekly for one month, then monthly for four months. Progress will be measured and tracked by the QA Committee. 5) The above corrective action will be completed no later than April 21, 2016.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441		4/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	03/02/2016

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 441	Continued From page 13 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed infection control practices for 4 of 4 sampled residents observed receiving blood glucose checks. Failure to disinfect the glucometer after use on each resident has the potential to spread infection to residents and staff. Findings include: Review of the facility policy titled "PROCEDURE FOR GLUCOMETER CHECKS" occurred on 03/02/16. This undated policy stated, ". . . PURPOSE: To ensure that standard precautions are carried out appropriately to reduce the risk of transmission of infection. PROCEDURE: . . . Upon completion of the accucheck [blood glucose check] . . . Wipe down the entire glucometer using a germacidal [sic] wipe . . ." Observation of blood glucose checks occurred on 02/29/16 from 5:03 p.m. to 5:35 p.m. The nurse (#8) failed to disinfect the glucometer after Resident #13's check and before Resident #14's	F 441	1) Education on the importance of sanitizing the glucometer in between each use will be provided at the mandatory April 21, 2016 All Staff Meeting. Facility management will search for appropriate sanitizer in convenient packaging for easier transport to resident rooms with glucometer. 2) All residents who require glucose monitoring have the potential to be affected. Continue to sanitize glucometers in between use to maintain infection control standards. 3) Education will be provided at the mandatory April 21, 2016 All Staff Meeting on the importance of sanitizing glucometers in between each use. 4) The DNS or designee will conduct biweekly audits on various licensed personnel for the duration of one month. After that point, audits will be conducted monthly for five months. Progress will be measured and tracked by the QA Committee. 5) The above corrective action will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	03/02/2016

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 441	Continued From page 14 check. She disinfected the glucometer after Resident #14 and checked Resident #15. The nurse (#8) failed to disinfect the glucometer after Resident #15 and before Resident #16's check. During an interview on 03/01/16 at 5:20 p.m., an administrative nurse (#9) stated facility staff are expected to disinfect the glucometer between residents.	F 441	completed no later than April 21, 2016.	