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 _____	02/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 02/11/19 and concluded on 02/14/19.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information	F 636		3/21/19

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

Electronically Signed | 03/01/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 636	Continued From page 1 regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to complete a comprehensive assessment at least once every 12 months for 1 of 8 sampled residents (Resident #18) who required an annual assessment. Failure to complete a comprehensive assessment may result in the facility not addressing changes in a resident's health,	F 636	1) The facility opened a comprehensive assessment for Resident #18 on February 13, 2019 to accommodate for the incorrect assessment dated January 1, 2019. The facility completed a comprehensive assessment for Resident #18 on February 27, 2019. 2) Another member of the IDT will validate each comprehensive assessment is the appropriate one for every resident	

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F 636	Continued From page 2 psychosocial, and mental status. Finding include: The Long-Term Care Facility RAI User's Manual (Version 1.16), dated October 2018, page 2-19 to 2-20 stated, ". . . Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required. The Assessment Reference Date (ARD) of an assessment drives the due date of the next assessment. The next comprehensive assessment is due within 366 days after the ARD of the most recent comprehensive assessment." Review of Resident #18's medical record occurred on all days of survey and identified a significant change Minimum Data Set (MDS), dated 01/09/18. The facility completed quarterly MDSs for the resident on 04/02/18, 07/02/18, and 10/02/18. The facility completed a quarterly MDS dated 01/01/19 rather than the required comprehensive/annual assessment. During an interview on 02/13/19 at 3:26 p.m., an administrative nurse (#1) confirmed the facility failed to complete a comprehensive assessment in January of 2019 for Resident #18.	F 636	after the assessment is opened. 3) Education will be provided to staff members who complete the comprehensive assessments on the appropriateness and timeliness of comprehensive assessments. 4) The DON or designee will perform audits that all comprehensive assessments are timely in the future. The audits will be performed in the following manner: weekly for one month, bimonthly for one month and monthly for four months. If errors are noted throughout the course of the audits, the Director of Nursing or designee will ensure the correct assessment is performed. A modification to the MDS will be performed, if necessary. The results of the audits will be provided and reviewed at monthly QAPI meetings. 5) The corrective action will be completed by March 21, 2019.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		3/21/19

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F 641	Continued From page 3 Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), review of the Advisory Committee on Immunization Practices (ACIP) recommendations, and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 5 of 13 sampled residents (Resident #1, #7, #13, #26, and #29) and 1 closed record reviewed (Resident #36). Failure to accurately complete Section A (Identification Information), Section N (Medications), Section O (Special Treatments, Procedures, and Programs), and Section P (Restraints and Alarms) of the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION A: IDENTIFICATION INFORMATION The Long-Term Care Facility RAI User's Manual, revised October 2018, page A-29 stated, ". . . Steps for Assessment: 1. Review the medical record including the discharge plan and discharge orders for documentation of discharge location. Coding Instructions: Select the 2-digit code that corresponds to the resident's discharge status. Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home. . . ."	F 641	1) Resident #36□s MDS dated November 22, 2018 was modified on February 27, 2019 to reflect discharge to community instead of discharge to acute hospital. Resident #26'□s MDS dated November 7, 2018 was modified on February 27, 2019 to reflect that they did not receive a hypnotic on any of the days in the seven day look back period. Resident #1'□s MDS dated November 22, 2018 will be modified by March 21, 2019 to reflect their appropriate pneumococcal immunization status. Resident #29'□s MDS dated April 30, 2018 will be modified by March 21, 2019 to reflect their appropriate pneumococcal immunization status. Resident #13□'s MDS□ dated January 19, 2019 will be modified by March 21, 2019 to reflect the side rails were not a restraint. Resident #7□s MDS dated December 13, 2018 will be modified by March 21, 2019 to reflect the wanderguard was used daily. 2) All residents have the potential to be affected by this deficient practice. The staff members that complete MDS□s will be mindful of accuracy and the deficient practices related to the specific inaccuracies noted. 3) Education will be provided to staff members who complete the MDS□s in regards to accurate coding. 4) The DON or designee will perform audits that check for accurate MDS coding. The audits will be performed in the following manner: weekly for one month, bimonthly for two months and monthly for three months. If errors are	

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F 641	Continued From page 4 - Review of Resident #36's medical record occurred on 02/14/19. The progress notes, dated 11/22/18, stated, ". . . Call placed to [physician's name] and orders received to change discharge to today as requested. . . . Taken to front door along with belongings for discharge home. . . ." Review of a Discharge Return Not Anticipated MDS, dated 11/22/18, identified A2100 coded as discharge to acute hospital. During an interview on 02/13/19 at 5:00 p.m., a nurse manager verified Resident #36 discharged home. The facility failed to correctly code A2100 as discharge to community (home). SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2018, pages N-6 and N-7, ". . . Steps for Assessment: 1. Review the resident's medical record for documentation that any of these medications were received by the resident during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). . . . N0410D, Hypnotic: Record the number of days a hypnotic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days. . . ." - Review of Resident #26's medical record occurred on all days of survey. A quarterly MDS, dated 11/07/18, identified a hypnotic administered on 7 occasions during the 7-day look-back period. Review of Resident #26's November 2018 electronic medication	F 641	noted throughout the course of the audits, the Director of Nursing or designee will ensure the MDS maintains accuracy and a modification will be completed, if necessary. The results of the audits will be provided and reviewed at monthly QAPI meetings. 5) The corrective action will be completed by March 21, 2019.	

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F 641	Continued From page 5	F 641		

administration record (eMAR) showed no hypnotic medication administered.

During an interview on 02/13/19 at 3:15 p.m., a nurse manager verified Resident #26 had no hypnotic medication administered during the month of November 2018.

The facility failed to correctly code Section N for medications administered.

SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

The Long-Term Care Facility RAI User's Manual, revised October 2018, pages O-11 to O-12 stated, ". . . O0300: Pneumococcal Vaccine Coding Instructions O0300A, Is the Resident's Pneumococcal Vaccination Up to Date? Code 0, no: if the resident's pneumococcal vaccination status is not up to date or cannot be determined. Proceed to item O0300B, If Pneumococcal vaccine not received, state reason. Code 1, yes: if the resident's pneumococcal vaccination status is up to date. . . . "Up to date" in item O0300A means in accordance with current Advisory Committee on Immunization Practices recommendations. . . ."

Review of the ACIP webpage (https://www.cdc.gov/vaccines/schedules/hcp/index.html. MMWR / September 4, 2015 / Vol. 64 / No. 34) stated, ". . . For immunocompetent adults aged > [greater than] 65 years who have not previously received pneumococcal vaccine, ACIP makes the following recommendation for intervals between PCV13 [13-valent pneumococcal conjugate vaccine] followed by

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F 641	Continued From page 6 PPSV23 [23-valent pneumococcal polysaccharide vaccine]: A dose of PPSV23 should be given >1 year following a dose of PCV13. The two vaccines should not be co-administered. If a dose of PPSV23 is inadvertently given earlier than the recommended interval, the dose need not be repeated. . . ." - Review of Resident #1's medical record occurred on all days of survey. The record showed Resident #1 received the PPSV23 vaccine on 12/24/96. The record lacked evidence the facility assessed the resident's pneumococcal immunization status for the PCV13 immunization, provided education to the resident and/or their legal representative, and additionally, failed to administer the vaccine. Review of the quarterly MDS, dated 11/22/18, showed facility staff incorrectly coded section O0300, Yes: up to date. - Review of Resident #29's medical record occurred on all days of survey. The record showed Resident #29 received the PCV13 vaccine on 04/01/15 (prior to admission). The record lacked evidence the facility assessed the resident's pneumococcal immunization status for the PPSV23 immunization, provided education to the resident and/or their legal representative, and additionally, failed to administer the vaccine. Review of the annual MDS, dated 04/30/18, showed facility staff incorrectly coded section O0300, Yes: up to date. SECTION P: RESTRAINTS and ALARMS The Long-Term Care Facility RAI User's Manual, dated October 2018, page P-1, defined physical	F 641		

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F 641	Continued From page 7	F 641		

restraints as "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." Page P-8, stated, "An alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident's clothing, motion sensors, door alarms, or elopement/wandering devices."

- On 02/11/19 at 2:19 p.m., observation showed Resident #13 in bed with bilateral quarter-size bed rails at the head of the bed. Observation showed the bed rails did not restrict the resident's movement.

Review of Resident #13's medical record occurred on all days of survey. A restraint assessment, dated 05/11/18, stated Resident #13's bed rails were not a restraint.

Resident #13's Care Area Assessment (CAA) Summary for Physical Restraints, dated 07/24/18, stated, "Resident uses bed rails often t/o [throughout] the day to assist with independence in bed mobility. Does not constrict movement in bed."

Resident #13's quarterly MDSs, dated 01/19/19 and 10/24/18, and annual MDS, dated 07/24/18, showed staff coded the resident's bed rails as restraints "used daily." The facility failed to code Item P0100A Bed rail correctly as "not used" as a restraint.

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F 641	Continued From page 8	F 641		

During an interview on 02/13/19 at 3:30 p.m., a nurse manager (#1) stated Resident #13 cannot lower the side rails but added the rails do not restrict her movement and should not have been coded as restraints.

- Observation throughout the survey showed Resident #7 wore a wanderguard on his left wrist.

Resident #7's care plan, dated 12/06/18, stated, ". . . Resident is able to walk independently. Elopement risk, Wanderguard left wrist. . . . PERSONAL ALARM: Wander Guard used to alert staff to resident's movement . . ."

Review of Resident #7's nurses' notes stated the following:
12/06/2018 at 11:15 a.m., ". . . Very apprehensive and anxious asking numerous times about 'my boys' and 'I have to find them and go, . . .' Wanderguard placed on left wrist after explanation . . . Is independently ambulatory and has exit seeking past."
12/06/2018 at 4:27 p.m., "Resident has been checking doors throughout facility as if to leave. Has security bracelet placed. . . ."
12/08/2018 at 3:58 p.m., "From about 6 pm after supper until 1900 [7:00 p.m.] resident was frequently asking staff about leaving. Wanted a suitcase if possible but a box would do. Had a box in room he had put some things in. Said once that he would walk to Mandan. . . ."

Resident #7's admission MDS, dated 12/13/18, identified the resident wandered on 1-3 days of the look-back period and identified a wanderguard was "not used." The facility failed to

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F 641	Continued From page 9 code Item P0200E wander/elopement alarm correctly as "used daily." During an interview on 02/13/19 at 3:30 p.m., a nurse manager (#1) stated Resident #7 does have a wanderguard and staff should have coded the alarm on the MDS.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		3/21/19

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F 656	Continued From page 10 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, resident interview, and staff interview, the facility failed to develop a comprehensive care plan for 3 of 13 sampled residents (Resident #1, #4, and #236). Failure to develop a care plan that includes the care and services to be provided to the resident may negatively impact the resident's quality of life. Findings include: Review of the facility policy titled "Care Plan" occurred on 02/14/19. This policy, dated November 2016, stated, ". . . Each resident will have an individualized, person-centered, comprehensive plan of care . . . Through use of departmental assessments, the Resident Assessment instrument and review of the physician's orders, any problems, needs and concerns identified will be addressed. . . ." - Review of Resident #4's medical record occurred on all days of survey. The current care plan, dated 01/16/19, stated, "The resident has	F 656	1) Resident #4's care plan was changed on February 28, 2019 to reflect Foley catheter, history of hematuria and clots requiring bladder irrigation, with specific goals and interventions such as medication for spasms which affect the color of the urine, catheter cares, treatment for irritation to glans of penis, monitoring color and consistency of urine, intake and output, use of warm blanket, adhesive catheter secure, and the role of the Hospice nurse in care, monitoring, and changing the catheter. Resident #1's care plan was changed on February 28, 2019 to reflect the prevention of pressure ulcers. Resident #236's care plan was changed on February 14, 2018 to reflect the use of daily insulin, QID Accucheks, and staff assistance with tubigrips. Complications related to low and high blood sugars could not be added to the care plan due to the fact that this resident expired on February 18, 2019. 2) All residents have the ability to be	

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F 656	Continued From page 11 chronic pain/discomfort R/T [related to] Metastatic Prostate Cancer E/B [evidenced by] bladder spasms. . . . Resident's pain is aggravated by: movement, sit to stand, laying down to sitting." Resident #4's physician orders stated the following: * 02/09/19, "Foley catheter . . . Change monthly and prn [as needed] (last changed January 8th) as needed for cath [catheter] change related to BENIGN PROSTATIC HYPERPLASIA WITH LOWER URINARY TRACT SYMPTOMS." * 02/12/19, "Change catheter every 6 weeks due to pain issues." On 02/11/19 at 3:32 p.m., observation showed a certified nurse aide (CNA) (#4) emptied Resident #4's catheter bag of 500 milliliters dark rust color urine. The CNA stated the resident took medication that colored the urine. The resident stated he has had the catheter about four months. Resident #4's nurses' notes stated the following: * 01/16/2019 at 11:15, ". . . History of metastatic prostate CA [cancer] . . . admitted with hematuria [blood in the urine]. . . . Started on continuous bladder irrigation and manual bladder irrigation to remove clots. Conditions and complications treated during most recent hospitalization: Started on Myrbetriq and Detrol for bladder spasms, . . . Skilled services to be provided: . . . Intake and Urinary output. Monitor color, consistency of urine and bladder spasms. . . ." * 02/1/2019 at 06:49 p.m., ". . . Writer also conferred with hospice nurses as Nystatin [anti-fungal cream] does not seem to be	F 656	affected by this deficient practice. All staff members capable of updating the care plans will be mindful of care plan accuracy and update the care plans on a timely basis. The communication binder located within the charting station will be utilized to update care plans and will serve as a communication between nursing staff and administrative staff to ensure accuracy. 3) Education will be provided to staff members who are capable of updating care plans in regards to accurate care planning. 4) The DON or designee will perform audits that check for accuracy of care plans. The audits will be performed in the following manner: weekly for one month, bimonthly for two months and monthly for three months. If errors are noted throughout the course of the audits, the Director of Nursing or designee will ensure the care plans maintain accuracy. The results of the audits will be provided and reviewed at monthly QAPI meetings. 5) The corrective action will be completed by March 21, 2019.	

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	355104	A. BUILDING _____ B. WING _____	02/14/2019

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F 656	Continued From page 12 improving irritation to glans [tip] of penis. Area looks more red and irritated today. . . ." * 02/7/2019 at 00:45 a.m., ". . . Urine remains orange from med [medication] but is clear with no blood. Pericares and cath care with soap and water after which hydrocortisone cream applied. . . . Adhesive cath secure placed per his preference rather than the cath secure strap." During an interview on the afternoon of 02/13/19, a nurse (#5) stated the Hospice nurse changed the resident's catheter during visits when the catheter was due to be changed. The facility failed to develop a care plan related to Resident #4's Foley catheter, history of hematuria and clots requiring bladder irrigation, with specific goals and interventions such as medication for spasms which affect the color of the urine, catheter cares, treatment for irritation to glans of penis, monitoring color and consistency of urine, intake and output, use of warm blanket, adhesive catheter secure, and the role of the Hospice nurse in care, monitoring, and changing the catheter. During an interview on 02/13/19 at 3:35 p.m., a nurse manager (#1) agreed Resident #4's care plan failed to include the Foley catheter and related interventions. - Review of resident #1's medical record occurred all days of survey. A "Wound Clinic Progress Note," dated 02/01/19, stated, ". . . Chief Complaint: Left ischial [buttock] stage 3 pressure ulcer . . . Pertinent Medical History: . . . History of Vascular Disease: Yes: CVA [cerebrovascular accident], PAD [peripheral	F 656		

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F 656	Continued From page 13	F 656		

artery disease] with history of left thrombectomy . . .History of Diabetes: Yes: type 2 . . . Plan: . . . left ischial pressure ulcer has resolved today . . . apply barrier cream to area with peri [perineal] cares for prevention . . . plan of care on referral for lakota good sam [sic] . . ." A "Clinical Referral" from the Wound Clinic, dated 02/01/19, included an order to apply barrier cream to the left ischium with perineal cares.

A Braden Scale Assessment, dated 01/21/19, identified Resident #1 as "High Risk" for pressure sores. Resident #1's care plan failed to include pressure ulcers and interventions for preventing a pressure ulcer.

During an interview on 02/13/19 at 9:30 a.m., an administrative nurse (#1) confirmed the care plan lacked interventions for preventing a pressure ulcer.

- Review of Resident #236's medical record occurred on all days of survey. Diagnoses included diabetes mellitus and edema. The current care plan stated, " . . . POSITIONING: Resident requires pillows, and elevation of lower extremities to aid relief of bilateral pedal edema. . . . FOCUS: The resident has Diabetes Mellitus. GOAL: Resident will have no complications related to diabetes . . . INTERVENTIONS: Diabetic nail care provided by licensed nurse. . . . "

Current physician orders included blood glucose checks four times a day.

Observation of Resident #236 on all days of survey identified elastic support socks on

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	355104	A. BUILDING _____ B. WING _____	02/14/2019

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F 656	Continued From page 14 bilateral feet and legs. Resident #236's care plan failed to include the use of elastic support socks, glucose monitoring and complications related to low and high blood sugars. During an interview on 02/13/19 at 2:30 p.m., an administrative nurse (#1) agreed the care plan failed to reflect interventions for Resident #236's edema, and interventions related to diabetes mellitus.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to transcribe and follow orders for 1 of 1 sampled resident (Resident #1) who received new orders from a wound specialist. Failure to transcribe and follow orders may result in skin breakdown. Findings include: Review of resident #1's medical record occurred all days of survey. A "Clinical Referral" from the Wound Clinic, dated 02/01/19, included an order to apply barrier cream to the left ischium (buttock) with perineal cares. The physician order summary and treatment record lacked evidence the facility transcribed the order from the wound	F 658	1) Resident #1's orders will be updated by March 21, 2019 to reflect "Apply barrier cream with peri cares." The order was not clarified to include "left ischium" due to the fact that the open area on the left ischium has been resolved. Resident #1's care plan was updated on February 28, 2019 to reflect "Cleanse buttocks and peri area with wipes and Tena cream with each brief change." Documentation is required every shift that barrier was applied with brief change. 2) All residents have the ability to be affected by this deficient practice. Nursing staff will transcribe orders as written and follow orders as written for all residents.	3/21/19

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F 658	Continued From page 15 specialist. Observation on 02/11/19 at 4:04 p.m. showed two unidentified staff members provided perineal cares for Resident #1 in his bed and failed to apply a barrier cream after cares. Observation on 02/12/19 at 9:41 a.m. showed a staff nurse (#3) and a certified nursing assistant (#4) provided perineal cares for Resident #1 in his bed and failed to apply a barrier cream after cares. During an interview on 02/13/19 at 9:30 a.m., an administrative nurse (#1) stated she expected the order from the wound specialist to be transcribed to Resident #1's medical record.	F 658	3) Education will be provided to staff members who are capable of transcribing orders in regards to ensure orders are inputted accurately and followed. 4) The DON or designee will perform audits that check for transcribing and implementation of orders. The audits will be performed in the following manner: weekly for one month, bimonthly for two months and monthly for three months. If errors are noted throughout the course of the audits, the Director of Nursing or designee will ensure the orders are transcribed and followed. The results of the audits will be provided and reviewed at monthly QAPI meetings. 5) The corrective action will be completed by March 21, 2019.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility	F 686	1) Resident #1's care plan was updated	3/21/19

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F 686	Continued From page 16 policy and procedure, and staff interview, the facility failed to provide the necessary care and services to prevent the development of pressure ulcers for 3 of 5 sampled residents (Resident #1, #15, and #21) with a history of pressure ulcers. Failure to consistently use interventions to prevent pressure ulcers may result in further skin breakdown. Findings include: Review of the facility policy titled "PRESSURE ULCER PRACTICE GUIDELINES" occurred on 02/13/19. This policy, revised September 2016, stated, ". . . Prevention Strategies [Planning/Implementation] . . . MOISTURE MANAGEMENT . . . in conjunction with a moisture barrier. . . . Employees should perform toileting actions that include checking for incontinence and/or offering to assist with bathroom needs. . . . MOVEMENT OR MANAGEMENT OF TISSUE LOAD . . . Employees should implement resident-specific turning and positioning programs based upon an individualized assessment. This includes a consistent program for changing the resident's position and realigning the body. . . ." - Review of resident #1's medical record occurred all days of survey. A "Wound Clinic Progress Note," dated 02/01/19, stated, ". . . Chief Complaint: Left ischial [buttock] stage 3 pressure ulcer . . . Pertinent Medical History: . . . History of Vascular Disease: Yes: CVA [cerebrovascular accident], PAD [peripheral artery disease] with history of left thrombectomy [blood clot removal] . . . History of Diabetes: Yes: type 2 . . . Plan: . . . left ischial pressure ulcer has	F 686	on February 28, 2019 to reflect "Cleanse buttocks and peri area with wipes and Tena cream with each brief change." Documentation is required for Resident #1 on every shift that barrier was applied with brief change. Resident #15 and #21 are appropriately care-planned for repositioning as of February 28, 2019 documentation is required to ensure repositioning occurs. 2) All residents have the ability to be affected by this deficient practice. Nursing staff will be mindful of residents that are stationary for long periods of time and will notify administrative staff immediately with any concerns. Developing an individualized repositioning schedule is required for those residents unable to position themselves and is based on nutrition, hydration, incontinence, diagnoses, mobility and observation of the resident's skin over a period of time. The Positioning Assessment and Evaluation UDA is a required tool that is used to determine an individualized repositioning schedule. 3) Education will be provided to staff members regarding the importance of repositioning and etiology behind skin breakdown. 4) The DON or designee will perform audits that check for pressure ulcer prevention. The audits will be performed in the following manner: biweekly for two months, weekly for one month and bimonthly for one month, and monthly for two months. If errors are noted throughout the course of the audits, the	

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F 686	Continued From page 17 resolved today . . . apply barrier cream to area with peri [perineal] cares for prevention . . . plan of care on referral for lakota good sam [sic] . . ." A "Clinical Referral" from the Wound Clinic, dated 02/01/19, included an order to apply barrier cream to the left ischium with perineal cares. The physician order summary and treatment record lacked evidence the facility transcribed the order from the wound specialist for 14 days. A Braden Scale Assessment, dated 01/21/19, identified Resident #1 as "High Risk" for pressure ulcers. Resident #1's care plan lacked interventions for preventing a pressure ulcer. Observation on 02/11/19 at 4:04 p.m. showed two unidentified staff members provided perineal cares for Resident #1 in his bed and failed to apply a barrier cream after cares. Observation on 02/12/19 at 9:41 a.m. showed a staff nurse (#3) and a certified nursing assistant (CNA) (#4) provided perineal cares for Resident #1 in his bed and failed to apply a barrier cream after cares. During an interview on 02/13/19 at 9:30 a.m., an administrative nurse (#1) stated she expected staff to apply barrier as part of their normal skin care regimen. She confirmed the care plan lacked interventions for preventing a pressure ulcer. - Review of Resident #15's medical record occurred on all days of survey. The annual Minimum Data Set (MDS), dated 08/05/18, identified moisture associated skin damage, and on a turning/repositioning program. A quarterly	F 686	Director of Nursing or designee will ensure pressure ulcer prevention strategies are being used, if appropriate. The results of the audits will be provided and reviewed at monthly QAPI meetings. 5) The corrective action will be completed by March 21, 2019.	

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F 686	Continued From page 18 MDS, dated 11/04/18, identified extensive assistance required for toileting and transfers, frequently incontinent of bowel and bladder and an open lesion on the foot. Resident #15's current care plan stated, " . . . toileting before and after periods of rest, before and after meals and PRN [as needed] to prevent skin breakdown from incontinence. . . . The resident has impaired cognitive function/dementia . . . Peripheral Vascular Disease R/T [related to] Heart disease and diabetes E/B [evidenced by] History of left lower leg cellulitis and toe ulcers. . . . history of reoccurring urinary tract infections . . ." Observation on 02/12/19 showed the following: * 7:54 a.m. to 10:50 a.m. Resident #15 seated in a wheelchair. * During an interview on 02/12/19 at 10:50 a.m., the CNA (#4) stated she would notify this surveyor of any transfers or cares provided for Resident #15. * From 10:51 a.m. to 12:05 p.m. Resident #15 remained in her wheelchair. *Observation at 1:14 p.m., showed Resident #15 in bed sleeping. - Review of Resident #21's medical record occurred on all days of survey. Diagnosis included diabetes mellitus and dementia. The quarterly MDS, dated 01/24/19, identified the resident as always incontinent of bowel and bladder, required extensive assistance with transfers and toileting, and the application of medication/ointment (other than to feet). A physicians order included a barrier cream to the reddened coccyx area as needed.	F 686		

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F 686	Continued From page 19 Resident #21's care plan stated, ". . . Resident will remain free of complications related to immobility, including . . . skin-breakdown . . . Toileting schedule: upon rising, before and after meals and rest periods. . . ." Observations on 02/12/19 showed the following: * 8:04 a.m. to 10:50 a.m. Resident #21 seated in a broda chair (adjustable positioning wheelchair). * During an interview on 02/12/19 at 10:50 a.m., the CNA (#4) stated she would notify this surveyor of any transfers or cares provided for Resident #21. * 10:51 a.m. to 11:52 a.m. Resident #21 remained in broda chair. * 1:14 p.m. Resident #21 in bed sleeping. During an interview on 02/12/19 at 2:05 p.m., a CNA (#4) confirmed Resident #15 and #21 had not been repositioned or toileted since before breakfast. The facility failed to reposition and/or toilet Resident #15 and #21 for over four hours. Failure to reposition may result in skin breakdown.	F 686		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		3/21/19

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	355104	A. BUILDING _____ B. WING _____	02/14/2019

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F 758	Continued From page 20 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced	F 758		

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F 758	Continued From page 21 by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure orders for as needed (PRN) psychotropic drugs were limited to 14 days and residents who use psychotropic medication receive gradual dose reductions (GDRs), unless clinically contraindicated, for 2 of 6 residents (Resident #8 and #16) reviewed for psychotropic medications. Failure to ensure the physician renewed the PRN order after 14 days (Resident #8) or attempt a GDR (Resident #16) placed residents at risk for receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: Review of the facility's policy titled "PSYCHOTROPIC MEDICATIONS" occurred 02/13/19. This policy, revised June 2017, stated, ". . . Gradual dose reductions must be done according to federal regulations. . . . PRN orders for psychotropic drugs are limited to 14 days. . . . Gradual Dose Reductions . . . Antipsychotics . . . Within the first year a resident is admitted on an antipsychotic medication or after the location has initiated an antipsychotic medication, the location must attempt a gradual dose reduction . . . After the first year, a GDR must be attempted annually, unless clinically contraindicated. . . ." - Review of Resident #16's medical record occurred on all days of survey. Physician orders identified amitriptyline 25 milligrams (mg) (antidepressant) started on 8/23/17. The record failed to identify a gradual dose reduction completed in 2018 or 2019.	F 758	1) Resident #16 has been recommended for a gradual dose reduction on Amitriptyline and it will be completed by March 21, 2019. Resident #8's re-order for the PRN medication cannot occur due to the fact that they expired on February 23, 2019. 2) All residents have the potential to be affected by this deficient practice. All PRN orders for for all residents for psychotropic drugs must have a stop date of 14 days or less. 3) Education will be provided to nursing staff members in regards gradual dose reduction timeliness and PRN orders for psychotropic medications being less than 14 days in duration. An educational reminder will be provided formally to our consultant pharmacist and, during the monthly medication review, our consultant pharmacist must complete the Monthly Medication Regimen Review, which complies with all applicable pharmacy standards. All attending primary physicians must sign "Medical Provider Guidelines" each year, which includes education on Unnecessary Psychotropic Medications. 4) The DON or designee will perform audits that check for gradual dose reductions and PRN psychotropic orders. The audits will be performed in the following manner: weekly for one month and monthly for five months. If errors are noted throughout the course of the audits, the Director of Nursing or designee will ensure gradual dose reductions and that	

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F 758	Continued From page 22 During an interview on 02/13/19 at 1:30 p.m. a nurse manager (#1) agreed no GDR had been completed for 2018 through 02/13/19. - Review of Resident #8's medical record occurred on all days of survey. Physician orders identified lorazepam 0.5 mg (antianxiety) PRN started on 12/17/18. The medication administration record identified 11 PRN administrations from February 1-12, 2019. The record failed to identify a new order after 14 days. During an interview on 02/13/19 at 2:30 p.m., an administrative nurse (#2) agreed the facility failed to re-order the medication after 14 days.	F 758	PRN orders for psychotropic medications are re-ordered every 14 days, if needed. The results of the audits will be provided and reviewed at monthly QAPI meetings. 5) The corrective action will be completed by March 21, 2019.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F 883		3/21/19

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	355104	A. BUILDING _____ B. WING _____	02/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

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F 883	Continued From page 23 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on policy review, review of the Centers for Disease Control and Prevention (CDC)	F 883	1) Resident #1 was given the Prevnar 13 on February 19, 2019 and Resident	

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F 883	Continued From page 24 guidelines and recommendations, record review, and staff interview, the facility failed to assess each resident's pneumococcal status and provide education to residents and/or their legal representatives regarding the benefits and potential side effects of receiving the vaccination for 2 of 5 sampled residents (Resident #1 and #29) reviewed for immunization status. Failure to implement a process to offer pneumococcal vaccine to all residents, provide education to residents and their legal representatives, and document the administration or refusal has the potential for non-immunized residents to contact pneumonia and also spread the infection to other residents, visitors, and staff. Findings include: Review of the facility policy titled "IMMUNIZATIONS FOR RESIDENTS," occurred on 02/13/19. This policy, revised November 2016, stated, ". . . Upon admission, each resident and/or resident representative will receive the Vaccination Information Statement (VIS) for influenza and pneumococcal vaccines. Discuss the benefits and potential side effects of vaccinations with the resident and/or resident representative. . . . If the resident and/or the resident representative consent to vaccinations for pneumococcal and annual influenza, follow procedures below. Obtain written consent if required by state regulations. Scan the signed consent into Resident Spaces using the indexing category of Consent for Immunizations (Inside). . . . The Vaccination Information Statements can also be found on the Centers for Disease Control and Prevention (CDC) website: www.cdc.gov/vaccines/hcp/vis/index.html. . . ."	F 883	#1's representative was provided education prior to administration. Resident #1 was given the Pneumovax 23 on December 24, 1996 and was provided education at that time. Resident #29 was given Prevnar 13 on April 1, 2015. The resident received education before that administration, although given outside of our facility and before this resident was admitted. Resident #29 will be given Pneumovax 23 by March 21, 2019. Resident #29 will be given education prior to administration the Pneumovax 23. Both residents will be in compliance with the pneumococcal guidelines of the CDC by March 21, 2019. 2) The Director of Health Information Management or designee with input pertinent immunizations records into the resident medical record upon admission. After such time, the residents will be evaluated for any other additional immunizations needed. 3) Education will be provided to staff members regarding the importance of maintaining immunization records and keeping resident influenza and pneumococcal immunizations up to date. Education will be provided to attending providers regarding the CDC guidelines for influenza and pneumococcal immunizations. 4) The DON or designee will perform audits that check that immunization status was reviewed upon admission and recommendation was made to the provider for any additional immunizations, if needed. The audit will also verify that, if	

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F 883	Continued From page 25 Review of the CDC: Vaccination Information Statements (VIS) webpage (https://www.cdc.gov/vaccines/hcp/vis/index.html), last updated October 12, 2018, stated, ". . . Pneumococcal conjugate vaccine (called PCV13) protects against 13 types of pneumococcal bacteria . . . is also recommended for . . . for all adults 65 years of age and older. Your doctor can give you details. . . . Pneumococcal polysaccharide vaccine (PPSV23) protects against 23 types of pneumococcal bacteria. . . . PPSV23 is recommended for: . . . All adults 65 years of age and older . . . Your healthcare provider can give you more information about these recommendations. . . ." - Review of Resident #1's medical record occurred on 02/13/19. The record showed Resident #1, admitted in 1996, received the PPSV23 vaccine on 12/24/96. The record lacked evidence the facility assessed the resident's pneumococcal immunization status for the PCV13 immunization and/or provided education to the resident and/or their legal representative. - Review of Resident #29's medical record occurred on all days of survey. The record showed Resident #29, admitted in 2016, received the PCV13 vaccine on 04/01/15 (prior to admission). The record lacked evidence the facility assessed the resident's pneumococcal immunization status for the PPSV23 immunization and/or provided education to the resident and/or their legal representative. During an interview on 02/13/19 at 1:45 p.m., an administrative nurse (#1) confirmed the facility	F 883	an immunization was administered, that education was provided to the resident or resident representative prior to administration. The audits will be performed in the following manner: weekly for one month, bimonthly for one month, and monthly for four months. If errors are noted throughout the course of the audits, the Director of Nursing or designee will ensure immunization status is updated and recommendations for additional immunizations are made. The results of the audits will be provided and reviewed at monthly QAPI meetings. 5) The corrective action will be completed by March 21, 2019.	

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F 883	Continued From page 26 does not have a process for notifying physicians of a resident's immunization status. She stated it was up to the physician to order an immunization for a resident who is not up to date. The facility failed to implement a process to to ensure each resident is offered pneumococcal vaccinations and facilitate communication with the provider of the residents' status.	F 883		