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	355097	A. BUILDING _____ B. WING _____	02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LARIMORE	501 E FRONT ST LARIMORE, ND 58251

(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 The standard Medicare/Medicaid recertification survey started on 02/20/18 and concluded on 02/22/18.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced	F 604		3/29/18

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

Electronically Signed | 03/16/2018

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F 604	Continued From page 1 by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to determine the affect a position change alarm device had on 2 of 2 sampled residents (Resident #5 and #6) observed with position change alarm device attached to their clothing and 1 of 1 sampled resident (Resident #2) seated on an alarm pad in the wheelchair. Failure to assess the impact the device had on the residents has the potential to act as a restraint by limiting their movement. Findings include: Review of the facility policy titled "RESTRAINTS" occurred on 02/22/18. This policy, dated October 2017, stated, ". . . Definitions: . . . Physical Restraints - 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 that restricts freedom of movement . . . a . . . Also included as restraints are location practices that meet the definition of a restraint, such as: . . . Personal alarms that discourage the resident from moving. . . . Anytime a device, material or equipment is attached or placed adjacent to the resident's body, a determination will be made by a licensed nurse as to whether it is or could be a restraint for the individual resident . . . " - Observations occurred on 02/20/18 at 5:23 p.m. and 02/21/18 at 6:00 p.m. as well as times throughout the survey of Resident #5 sitting in a wheelchair. The back of the wheelchair showed a position change alarm, with the string from the device attached to the resident's clothing. If the	F 604	Resident #5's care plan has been updated to include the chair alarm. The assessment "Physical Device and Restraint Review" was completed on March 13, 2018. The assessment "Physical Device and Restraint Review" was completed for resident #6 for the chair alarm on March 13, 2018. "Physical Device and Restraint Review" assessments were completed for resident #2 for the SecureCare, bed and chair alarms on March 13, 2018. All residents that have SecureCare, a bed or chair alarm have the potential to be affected. The MDS nurse will review the care plans to ensure that the alarms are on the care plan and will check to see that an assessment is in place. Care plans and assessments will be updated as necessary. On a quarterly basis, an assessment will be completed on all SecureCare bracelets and all bed and chair alarms. Nurses will receive education on the appropriate use and procedures for adding or removing a SecureCare bracelet and a bed or chair alarm by a Good Samaritan nurse consultant on March 26, 2018. Instruction on filling out the form "Physical Device and Restraint Review" will be given.	

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F 604	Continued From page 2 resident attempted to stand, the string would pull and an alarm would sound. Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia, depression, and anxiety. A quarterly Minimum Data Set (MDS), dated 11/20/17, identified short and long term memory problems, moderately impaired cognition, and a chair alarm used daily. Current physician's orders stated, ". . . May have chair alarm to alert staff of need to assist. . . ." Resident #5's current care plan lacked information regarding the use of the device. The record lacked an assessment for the position change alarm device. - Observations occurred on 02/20/18 at 4:27 p.m. and 5:25 p.m., and on 02/21/18 at 11:31 a.m., as well as times throughout the survey of Resident #6 sitting in a wheelchair. The back of the wheelchair showed a position change alarm, with the string from the device attached to the resident's clothing. If the resident attempted to stand the string would pull and an alarm would sound. Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia and anxiety. A significant change MDS, dated 11/20/17, identified short and long term memory problems, moderately impaired cognition, and chair alarm used daily. Current physician's orders stated, ". . . Bed and chair alarm to alert staff for need for assist . . ." The current care plan stated, ". . . The resident is	F 604	Four resident care plans and charts will be audited monthly, for four months, then quarterly for 3 quarters by the DON or designee, to ensure that the alarms and SecureCare are on the care plan and current assessments are in place. The initial audit will be completed by the Social Worker by March 29, 2018. Results of the audits will be reviewed by the QAPI committee for recommendations and/or follow-up.	

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F 604	Continued From page 3 at risk for falls . . . PERSONAL ALARM: bed and chair used to alert staff to resident's movement and to assist staff in monitoring movement. . ." The record lacked an assessment for the position change alarm device. - Observations occurred on 02/21/18 at 10:15 a.m. as well as times throughout the survey of Resident #2 sitting in a wheelchair with pad alarm under cushion, whenever the resident attempted to stand, the alarm would sound. Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia, depression, and anxiety. The quarterly Minimum Data Set (MDS), dated 11/14/17, identified severely impaired cognition and a chair/bed alarm used daily. Current physician's orders stated, ". . . May have chair alarm to alert staff of need to assist. . . . secure care to alert staff of resident need for assist . . ." Resident #2's current care plan stated, ". . . bed and chair alarms used to alert staff to resident's movement. . . . WanderGuard used to alert staff to resident's movement and to assist staff in monitoring movement. . . . " The record lacked an assessment for either of the alarm devices. During an interview on 02/21/18 at 4:00 p.m., an administrative nurse (#1) when asked about an assessment for the position change alarms, stated, "We do not have an assessment for the alarm." When asked about the reason for the alarm, the staff member (#1) reported they are used for "weakness and falls," and "to alert staff when the resident doesn't use the call light due to	F 604		

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F 604	Continued From page 4 impaired cognition."	F 604		
F 641 SS=D	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: Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.15), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 2 of 12 sampled residents (Resident #2 and #15). Failure to ensure Section N (Medications) of Resident #15's and Section P (Restraints and Alarms) of Resident #2's MDS accurately reflect the current status/needs, has the potential to affect the accurate development of the comprehensive care plan and the care provided. Findings include: SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2017, page N-7 stated, ". . . N0410A, Antipsychotic: Record the number of days an antipsychotic 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 #15's medical record occurred on all days of survey. Review of the resident's current MDS, dated 12/18/17, showed	F 641	Section N0410A of the MDS for resident #15 was modified to take off the antipsychotic medication and submitted to CMS and the state on March 12, 2018. Section P0100E of the MDS for resident #2 was modified to add the wander/elopement alarm and was submitted to CMS and the state on March 12th, 2018. All residents that have an antipsychotic medication coded on the MDS and all residents that wear a wander/elopement alarm have the potential to have an inaccurate MDS. The MDS nurse will run the report "MDS Resident Matrix". All MDS's that trigger on the report with antipsychotic medications will have Section N 0410A reviewed to ensure the antipsychotic medications are coded correctly. Section P0100E of the MDS of all residents that wear a wander/elopement alarm will be reviewed to ensure it is coded correctly. If any coding discrepancies are found, the MDS will be modified and re-sent to CMS and the state.	3/29/18

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F 641	Continued From page 5 Resident #15 received an antipsychotic medication every day of the 7-day look-back period. The December electronic medication administration record (eMAR) failed to show this resident received an antipsychotic medication during the 7-day look-back period. SECTION P: RESTRAINTS AND ALARMS Observation on 02/21/18 at 10:15 a.m. showed Resident #2 with a left ankle wander-guard. The Long-Term Care Facility RAI User's Manual, revised October 2017, page P 8-10 stated, ". . . P0200 . . . Wander/elopement alarm includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn by/attached to the resident that activate an alarm and/or alert the staff when the resident nears or exits a specific area or the building. This includes devices that are attached to the resident's assistive device (e.g., walker, wheelchair, cane) or other belongings. . . ." Review of Resident #2's current MDS, dated 11/14/17, failed to show this resident wore a wander/elopement alarm during the look-back period. During an interview on the afternoon of 02/22/18, an MDS nurse (#3) agreed she failed to code the above sections of the MDS accurately.	F 641	If a resident is put on a new medication and there is any question if it is an antipsychotic, we will check with our pharmacist consultant for the classification of the medication. The MDS's nurses will receive education on coding sections N0410A and Section P0100E of the MDS by our Clinical Compliance Consultant on March 22, 2018. All nurses will receive education on the procedures for adding/removing SecureCare bracelets by a nurse consultant on March 26, 2018. The report "MDS Resident Matrix" will be run monthly for 4 months, then quarterly for 3 quarters and the DON or designee will audit section N0410A of the MDS's to ensure correct coding of antipsychotic medications. The MDS's of all residents with a wander/elopement alarm will audited monthly for 4 months, then quarterly for 3 quarters, to ensure accurate coding. Initial audits will completed by Clinical Compliance Consultant by March 29, 2018. Results of the audits will be reviewed by the QAPI committee for recommendations and/or follow-up.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		3/29/18

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F 657	Continued From page 6 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plans to reflect the residents' current status for 2 of 12 sampled residents (Resident #5 and #6). Failure to review/revise the care plans to reflect the residents' current status limited the staff's ability to communicate needs and ensure continuity of care for each resident. Findings include:	F 657	The care plans of resident #5 and #6 were updated to include the drug classification and the adverse side effects of Risperdal on March 15, 2018. The care plan of resident #5 was also updated to include the chair alarm on March 15, 2018. All residents that use antipsychotic medications and all residents that have a chair alarm have the potential to be	

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F 657	Continued From page 7 Review of the facility policy titled "Comprehensive Care Plan and Care Conferences" occurred on 02/22/18. This policy, dated February 2018, stated, ". . . 5. Formulating the Care Plan a. The care plan is driven by identified resident issues/conditions and their unique characteristics, strength and needs. . . . f. If a resident has specific behavioral interventions, they need to be reflected on the care plan . . . Unstable diagnoses that are currently being treated and are not addressed elsewhere in the plan of care. . . " - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia, anxiety, and hallucinations. Current physician's orders identified Risperdal (an antipsychotic medication) 0.5 milligrams (mg) one time a day and a chair alarm. Resident #5's current care plan stated, ". . . The resident is resistive to care R/T [related to] dementia and anxiety E/B [evidenced by] hits out at times and yells at staff and need for medication . . . Interventions: If resident resists with ADLs [activities of daily living], reassure resident, leave and return 5-10 minutes later and try again." The care plan failed to address the use of this medication for Resident #5. Observations during the survey showed Resident #5 with a position change alarm on his wheelchair. The care plan failed to address this device. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses	F 657	affected by an incomplete care plan. Social Services will review the care plans of all residents that take an antipsychotic medication to ensure that the drug classification and adverse effects of the drug are on the care plan. The therapy coordinator will review the care plans of all residents that have a chair alarm to ensure the chair alarm is on the care plan. The care team will receive education from the DON on putting the classification and adverse effects of antipsychotic medications on the care plans. The DON gave education to the nurses on March 8, 2018 and to the CNA's on March 7 and 14, 2018 on the importance of reviewing the care plans and being aware of the possible adverse effects of antipsychotic medications. Audits on the care plans of all residents on antipsychotic medications and all residents that have chair alarms will be completed monthly for four months, then quarterly for 3 quarters, by the DON or designee, to ensure these elements are on the care plan, and have the correct information. Initial audit will be conducted by March 29, 2018. The results of the audits will be reviewed by the QAPI committee for recommendations and/or follow-up.	

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F 657	Continued From page 8 included dementia and anxiety. Current physician's orders identified Risperdal 0.25 mg one time a day and 0.5 mg one time a day. Resident #6's care plan stated, ". . . The resident has a behavior symptom R/T dementia E/B exit seeking, tearful, and swearing, and need for medication [sic] hitting out, delusions, hallucinations noted . . ." The care plan failed to address the use of this medication for Resident #6. During an interview on 02/22/18 at 1:00 p.m., an administrative nurse (#1) agreed Resident #5 and #6's care plans should indicate the use of antipsychotic medications.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility procedure, review of a professional reference, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 2 sampled residents (Resident #2) observed during a gait belt transfer. Failure to properly use a gait belt during transfers placed the resident at risk of accidents and injury.	F 689	Resident #2 is being transferred with the use of a gait belt. CNA #2 has been re-educated on the importance of using the gait belt on all transfers. All residents that need assistance with transfers have the potential to be affected. The CNA's received education	3/29/18

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F 689	Continued From page 9 Findings include: Review of the facility procedure for "Ambulation of Resident" occurred on 02/22/18. This procedure, dated October 2017, stated, ". . . To prevent accidents when ambulating residents . . . Use gait belt, if necessary, around resident's waist to help resident maintain balance. . . ." Berman, Snyder, and Frandsen, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th edition, Pearson Education, Inc., New Jersey, page 1054, stated, ". . . If the client is a low safety risk . . . use a gait/transfer belt for standby assist as needed and assistive devices as needed . . . and 1-2 caregivers. Make sure the belt is pulled snugly around the client's waist and fastened securely. Grasp the belt at the client's back . . ." During an observation on 02/21/18 at 10:15 a.m., the certified nurse assistant (CNA) (#2) transferred Resident #2 from her bed to wheel chair (W/C) without a gait belt. During an interview on 02/22/18 at 11:05 a.m., an administrative nurse (#1) stated she experts staff to use a gait belt with transfers.	F 689	on March 7 and 14th and the nurses on March 8 on the importance of always using gait belts with transfers. Four audits on transfers were conducted on March 9, 16 and 20th.The DON or designee will audit four transfers by March 29, 2018, then monthly for 3 months, then quarterly for 2 quarters to ensure gait belts are being used. Results of the audits will be reported to the QAPI Committee for recommendations and/or follow-up.	