STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355097	A. BUILDING _____ B. WING _____	03/04/2020

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 03/01/20 and concluded on 03/04/20.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		4/8/20

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

Electronically Signed | 04/01/2020

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F 578	Continued From page 1 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to ensure the residents' rights to request, refuse, and/or discontinue treatment for 6 of 16 sampled residents (Resident #2, #10, #17, #28, #32, and #136) reviewed for advance directives. Failure to discuss the residents' advance care planning wishes, including resuscitation status, procure physicians' orders reflective of the residents' wishes, and ensure signed documentation of the residents wishes by the resident or their authorized representatives limited the facility's ability to communicate to direct care staff and emergency personnel the residents' wishes in the event of a medical emergency. Findings include: Review of the facility policy titled "Advance Care Planning and Advance Directives" occurred on 03/04/20. This policy, revised April 2016, stated, ". . . Purpose: To provide each resident the opportunity to make decisions regarding future medical care . . . Through compassionate interaction and education, assist residents to make their own choices regarding well-being and treatment. To define a process to assist residents/families and healthcare	F 578	1. Advance care planning has been discussed and documented with resident and/or resident representative for resident□s #2, #10, #17, #28, #32, and #136. 2. All residents have the potential to be affected by this deficient practice. Residents□ medical records will be reviewed to identify if advance care planning has been discussed and documented. Advance care planning discussions will be held as necessary. 3. The facility will follow our Policy and Procedure titled Advance Care Planning and Advance Directives. The Director of Social Services and Charge Nurses will be re-educated and review our Policy and Procedure titled "Advance Care Planning and Advance Directives" by 4/8/20. 4. The administrator or designee will audit all residents□ medical records to ensure compliance with our policy and procedure titled Advance Care Planning and Advance Directives. Audits will occur monthly x3 months, then quarterly x3 quarters. Results of audits will be submitted to QAPI committee for further recommendation.	

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F 578	Continued From page 2	F 578		

decision-makers in advance care planning. . . ."

- Review of Resident #2's medical record occurred on all days survey. The record showed the facility admitted Resent #2 on 11/30/18. The record included a physician order stating, ". . . Advance Directive: Do Not Resuscitate (DNR), Do not intubate (DNI) . . ."

The record lacked evidence of a discussion with the resident and/or resident's family/legal representative regarding what their current wishes entailed, including resuscitation.

- Review of Resident #10's medical record occurred on all days of survey. The record showed the facility admitted Resident #10 on 09/20/2019. The record included a physician's order stating, ". . . Advance Directive: DNR . . ." The current Minimum Data Set (MDS), dated 12/16/19, showed Resident #10's cognition as severely impaired.

A Hospital Admission History and Physical progress note, dated 09/18/19, stated, ". . . Chief Complaint: Confused. . . . The patient . . . noted to have tiredness, and confusion state . . . I had a detailed discussion regarding the code status with the patient and patient wants to be DNR. . . ."

The record lacked evidence the resident's family/legal representative was included in the discussion regarding his code status.

- Review of Resident #17's medical record occurred on all days survey. The record showed the facility admitted Resident #17 on 08/01/14.

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F 578	Continued From page 3	F 578		

The record included a physician order stating, ". . . Advance Directive: DNI-DNR . . ."

The record lacked evidence of a discussion with the resident and/or resident's medical power of attorney (POA) regarding what their current wishes entailed, including resuscitation.

- Review of Resident #28's medical record occurred on all days survey. The record showed the facility admitted Resident #28 on 01/26/18. The record included a physician order stating, ". . . Advance Directive: DNR . . ."

The record lacked evidence of a discussion with the resident and/or resident's family/legal representative regarding what their current wishes entailed, including resuscitation.

- Review of Resident #32's medical record occurred on all days survey. The record showed the facility admitted Resident #32 on 05/16/11. The record included a physician order stating, ". . . Advance Directive: Do hospitalize, Do resuscitate (CPR) . . ."

The record lacked evidence the resident and/or resident's family/legal representative agreed with/signed the ND (POLST) Physician Orders for Life-Sustaining Treatment form which indicated his code status.

- Review of Resident #136's medical record occurred on all days survey. The record showed the facility admitted Resident #136 on 02/14/20. The record included a physician order stating, ". . . Advance Directive: CPR . . ."

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F 578	Continued From page 4 The record lacked evidence of a discussion with the resident and/or resident's family/legal representative regarding what their current wishes entailed, including resuscitation. During an interview on 03/03/20 at 2:09 p.m., an administrative staff member (#1) confirmed the facility does not have signed code status documents for every resident, and stated, "The facility uses the physician order."	F 578		
F 656 SS=F	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	F 656		4/8/20

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F 656	Continued From page 5 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (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 record review, review of facility policy, and staff interview, the facility failed to develop a comprehensive care plan for 15 of 16 sampled residents (Resident #1, #2, #3, #7, #8, #9, #10, #17, #22, #23, #24, #28, #32, #34, and #136) and 1 of 2 closed records (Resident #36) reviewed. Care planning drives the type of care and services a resident receives and 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 03/04/20. This policy, revised December 2019, stated, ". . . Each resident will have an individualized, person-centered, comprehensive care plan that will include measurable goals and timetables, directed towards achieving and maintaining the resident's	F 656	1. Resident□s #1, #2, #7, #9, #10, #17, #22, #23, #28, #32 and #34□s care plans have all been updated to reflect wishes regarding discharge planning. Resident #3 and #24's care plans have been updated to reflect wishes for discharge planning, and diuretic usage. Resident #8□'s care plan has been updated to reflect wishes for discharge planning and psychotropic med usage. Resident #136's care plan has been updated to reflect wishes for discharge planning and food intolerances. 2. All residents have the potential to be affected. The MDS nurse or Case Manager will review care plans to ensure that discharge planning, diuretic usage, psychotropic medication usage, and food intolerances are care planned per policy. Care plans will be updated as necessary. 3. The Director of Social Services, MDS	

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F 656	Continued From page 6 optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. . . ." - Review of Resident #1, #2, #7, #9, #10, #17, #22, #23, #28, #32, and #34 medical record occurred on all days of survey. The care plans failed to address the resident's and/or their representatives wishes regarding discharge planning. - Review of Resident #3's medical record occurred on all days of survey. A physician's order dated 02/27/19, identified Resident #3 received Hydrochlorothiazide (a diuretic) daily for hypertension. The resident's care plan failed to reflect the signs/symptoms of edema/fluid retention, retention, possible side effects of the medication, and/or other interventions. Resident #3's care plan also failed to address the resident's and/or their representative's wishes regarding discharge planning. - Review of Resident #8's medical record occurred on all days of survey. A physician's order, dated 11/27/19, identified Resident #8 received Lorazepam (a psychotropic) daily for anxiety. The care plan failed to reflect the signs/symptoms of anxiety and/or the possible side effects of the antianxiety medication. Resident #8's care plan also failed to address the resident's and/or their representative's wishes regarding discharge planning. - Review of Resident #24's medical record occurred on all days of survey. A physician's order, dated 06/26/19, identified Resident 24 received Lasix (a diuretic) daily for edema. The	F 656	Coordinator, Case Manager, and Charge Nurse□s will all be re-educated and review the policy and procedures titled "Care Plan", and "Discharge Planning". This re-education will be completed by 4/8/20. 4. The Director of Nursing or Designee will audit 3 residents care plans for accuracy weekly X3 weeks, 5 residents care plans monthly X3 months, and 5 residents care plans quarterly X3 quarters. Results of audits will be submitted to QAPI committee for further recommendation.	

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F 656	Continued From page 7	F 656		

resident's care plan failed to reflect the signs/symptoms of edema/fluid retention, possible side effects of the medication, and/or other interventions. Resident #24's care plan also failed to address the resident's and/or their representative's wishes regarding discharge planning.

- Review of Resident #136's medical record occurred on all days of survey. The care plan and diet card identified Resident #136 on a regular diet, but failed to address the resident's food intolerances. Resident #136's care plan also failed to address the resident's and/or their representative's wishes regarding discharge planning.

During an interview on 03/04/20 at 8:44 a.m., when asked questions pertaining to Resident #136's food intolerances, a dietary staff member (#2) reported "[Resident #136] chooses her own food. Her family brings in special cereal and other foods." The dietary staff member (#2) indicated she would add the resident's food intolerance to her care plan.

During an interview on 03/04/20 at 10:45 a.m., an administrative staff member (#1) confirmed the discharge plans were not included in the residents' care plans.