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 JAN 3 2011	12/08/2010

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 For the standard Medicare/Medicaid survey started on 12/06/10 and completed on 12/08/10, the sample included two (2) residents for complete review, eight (8) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of Federal and State Law.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rita J. Rafferty — TITLE: Administrator — (X6) DATE: 12-31-10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355097	A. BUILDING _____ B. WING _____	12/08/2010

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 225	Continued From page 1 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, policy and procedure review, and staff interview, facility staff failed to report alleged abuse per facility policy for 1 of 4 abuse allegations, which occurred within the past year. Failure to report abuse or neglect in a timely manner to administrative staff could cause a delay of investigation and the potential for further resident abuse or neglect. Findings include: Review of the facility policy titled "Abuse and Neglect" occurred on the afternoon of 12/07/10. This policy, revised October 2009, stated, "Purpose . . . To ensure that all identified incidents of alleged or suspected abuse/neglect are promptly . . . reported . . . 1. If a staff member receives an allegation of abuse, neglect, or misappropriation of resident property or witnesses suspected abuse, neglect, or misappropriation of resident property, the staff member will immediately report this to a supervisor . . ." Review of abuse and neglect investigation reports occurred on the afternoon of 12/07/10. Review of the reports revealed: *Two CNAs (#13) and (#14) reported an allegation of verbal abuse and neglect on	F 225	CNA's #13 and 14 brought forth abuse allegations on 08/10/10 to DON and Administrator and were immediately interviewed and re-educated on timely notification of suspected abuse. CNA #15 was terminated on 08/12/10. All residents have the potential to be affected by abuse or neglect. All staff will be educated on timely reporting of abuse or neglect. An Abuse/Neglect Incident Tacking Log has been developed to include the date an allegation of mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of resident property is reported to a supervisor, to include the date the state is notified and to include the date of the follow up report to the state. An audit of the incident tracking log will be reviewed monthly by DON or designee. Results of audits will be reported at the Quality Assurance Committee for further recommendations.	01/17/11

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 _____	12/08/2010

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 225	Continued From page 2 08/10/10 committed by another CNA (#15) on 07/26/10 (two weeks prior). Interview of an administrative staff member (#16) occurred on 12/07/10 at 5:00 p.m. The staff member stated the expectation of the facility is immediate reporting of alleged abuse before the employee leaves the facility for the day.	F 225		
F 280 SS=B	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to review and revise the comprehensive care plans for 4 of 10 sampled residents (Resident #1, #4, #6, and #7).	F 280		

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 _____	12/08/2010

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 280	Continued From page 3 Failure to review and revise the resident care plans limited the staff's ability to communicate the care needs of each resident and limited the staff's ability to ensure continuity of care for each resident. Findings include: - Resident #7's current care plan, dated 11/30/2010, stated, "Problem: . . . Alteration in mood . . . Plan: . . . notify . . . Hospice prn [as needed] of significant changes in mood or behavior . . . Problem: . . . Alteration in skin . . . Plan: . . . notify . . . Skin treatments as ordered per . . . Hospice. Meds [medications] as ordered per . . . Hospice . . . Problem: . . . Alteration in bowel and bladder . . . Plan: . . . Monitor bowel habits daily. Notify . . . Hospice prn of persistant diarrhea or constipation . . . Problem: . . . Alteration in nutrition . . . Plan: . . . Diet: . . . covered cups, lip plate . . ." The care plan failed to indicate the resident no longer required Hospice services or therapeutic dishware (ie: covered cups and/or lip plates). Observation of cares provided to Resident #7 revealed the following: * On 12/06/10 at 5:35 p.m., 12/07/10 at 7:50 a.m. and 11:15 a.m., facility staff transported Resident #7 to the dining room for meals. The staff provided tray set-up prior to each meal. Her trays did not contain any therapeutic dishware (ie: covered cups and/or lip plates). Review of Resident #7's medical record occurred on all days of survey. The Physician's Orders, dated 11/22/10, stated, "[No] longer on hospice as of midnight."	F 280	The care plans for residents #1, #4, #6 and #7 have been updated to reflect current care. All residents have the potential to be affected in this area. All care plans will be reviewed by the care team and revised as needed to ensure they reflect the current plan of care. The nursing department has received education on the need to revise and update plans of care Follow up audits to ensure the review and revision of care plans will be completed by Social Worker or designee. Five care plans audits will be completed monthly for two months, then five care plans quarterly for 3 quarters. Results of audits will be reported at the Quality Assurance Committee for further recommendations.	01/17/11

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 _____	12/08/2010

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 280	Continued From page 4	F 280		

During interview, on December 7, 2010, at 4:30 p.m., a supervisory dietary staff member (#1), stated, "She [Resident #7] was not doing well after she got out of the hospital. She is a lot different now - much better. She is so much better, she doesn't need it [therapeutic dishware] anymore. I did not update her care plan."

During interview, on December 8, 2010, at 11:30 a.m., an administrative nursing staff member (#2), agreed the resident's current care plan should have been updated to reflect her discharge from Hospice services.

Facility staff failed to revise/update Resident #7's care plan to reflect she no longer required Hospice services and/or had need for therapeutic dishware.

- Review of Resident #1's medical record occurred on all days of the survey. Diagnoses included recurrent urinary tract infection (UTI) and osteoarthritis. The quarterly Minimum Data Set (MDS), dated 12/01/10, indicated Resident #1 was independent with walking in room, required supervision with locomotion on and off the unit, and limited assistance with toileting. The MDS also identified Resident #1 as continent of bladder.

Resident #1's careplan, dated 09/27/10, included the problem, "Alteration in mobility r/t [related to] poor balance, and weakness, arthritis . . . Plans and approaches: . . . Nursing to walk to all meals with walker and use of gait belt with limited assist bid [twice daily]; stand at parallel bars or walker marching, semi squats, hip abduction x [times] 20 reps [repetitions] each with stand by assist 5 x wk [week]; seated long arh [sic] quads 3# [pounds] x

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 _____	12/08/2010

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 280	Continued From page 5	F 280		

30, hip flexion 3# x 30 both legs with weight placement 5 x wk; and upper extremity exercises with WII [exercise game] 2 x wk . . ." The approaches also included, "Ambulation with FWW [front wheeled walker] for 200 feet or more with contact guard assist . . . 5 x wk, and lower and upper extremity exercises 6 x wk." Review of the treatment record showed only these two approaches signed off as completed by restorative therapy staff.

Resident #1's careplan included the problem, "Alteration in bowel/urinary elimination r/t weakness, needs assist m/b [manifested by] VRE [vancomycin resistant enterococcus] of urine . . . Plans and approaches: . . . Contact precautions with urine, use of good universal precautions."

On 12/06/10 at 4:52 p.m., observation showed Resident #1 wheeled herself to the dining room for supper. During an interview on 12/07/10 at 10:58 a.m., Resident #1 stated she wheeled herself to the dining room for lunch, and she hasn't walked to meals since she fell last month.

On all days of the survey, observation showed Resident #1 independent with toileting and failed to show an isolation cart or sign by Resident #1's room.

During an interview on 12/08/10 at 11:59 a.m., an administrative nurse (#2) agreed the staff failed to update Resident #1's careplan related to restorative therapy, contact isolation, and history of VRE.

- Review of Resident #4's medical record occurred on all days of the survey. Diagnoses included a history of UTI. The quarterly MDS,

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 _____	12/08/2010

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 280	Continued From page 6	F 280		

dated 10/28/10, showed Resident #4 with an indwelling catheter and continent of bladder.

Resident #4's careplan included the problem, dated 11/04/10, "Potential for alteration in skin integrity r/t needs assist with mobility. DX [diagnosis] MRSA [methicillin resistant staphylococcus aureus], occasional incontinent of bowel and bladder, s/p [suprapubic] cath [catheter]. . . . Plans and approaches: . . . Use of universal precautions. Contact precautions for any drainage from catheter site."

On all days of the survey, observation failed to show an isolation cart or sign by Resident #4's room, or use of contact precautions in his cares.

During an interview on 12/07/10 at 3:45 p.m., an administrative nurse (#9) stated, "He [Resident #4] was treated for MRSA in October 2009, so he no longer has active MRSA and staff only need to use universal precautions. Contact isolation should not be on his careplan."

- Review of Resident #6's medical record occurred on December 06-08, 2010. Resident #6's current plan of care stated, ". . . Skin tears to top of Lt. [left] hand on 10-5-10 . . . Skin tear will heal [without] infection by 10/31/10 . . ."

Observation of Resident #6 on December 06-07, 2010 showed this resident did not have a skin tear to the top of her left hand. Facility staff failed to revise/update Resident #6's care plan to reflect that this resident currently does not have a skin tear on her left hand.

During an interview on the morning 12/08/2010. and administrative nursing staff member (#2)

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 _____	12/08/2010

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 280	Continued From page 7 confirmed the facility staff failed to update Resident #6's plan of care to reflect this skin tear had healed and no longer existed.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy/procedure review, and staff interview, the facility staff failed to implement a scheduled toileting plan for 1 of 3 sampled residents (#3)incontinent of bladder and observed to be toileted. Failure to implement a scheduled toileting plan, at the times consistent with this residents' plan of care, places the resident at increased risk for urinary tract infections, avoidable increased bladder incontinence, skin breakdown, and also has the potential to compromise the residents' individual dignity. Findings include: Review of the facility policy/procedure titled, "Toileting Programs" occurred on 12/08/10. This policy/procedure, revised September 2010, stated, "Purpose To assist in the selection of an	F 315		

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 _____	12/08/2010

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 315	Continued From page 8 appropriate toileting program for the resident. To regain continence and bladder function dignity . . . Scheduled Toileting. This technique is recommended for residents: * Who have infrequent or irregular voiding patterns * With stress, urge or mixed incontinence physical [sic] or who have cognitive impairments and may not be able to participate in independent toileting * Who are not aware of the urge to void (urge sensation) * Who have been adverse to attempting any type of program Goal: To reduce incontinence episodes and keep the resident dry, not to modify bladder Program: Timed toileting on a rigid fixed schedule usually every two to four hours during waking hours. Interval does not change and toileting takes place whether there is a sensation to void or not . . ." Review of Resident #3's medical record occurred on December 06-08, 2010. Medical diagnoses include, in part, dementia, urinary tract infection due to E coli 10/25/10, pyelonephritis (kidney infection) 10/25/10, and urinary frequency. The current quarterly Minimum Data Set (MDS) for Resident #3, dated 10/29/10, identified the following: dementia, sometimes understood, sometimes understands others, occasionally incontinent of bladder, and requires extensive assistance of one person for toileting. For Resident #3, the current Resident Assessment Protocol (RAP) for urinary incontinence, completed with the 05/17/10 MDS, stated, ". . . R/T [related to] occasional incontinent	F 315	The toileting plan for resident #3 was reviewed and updated. All residents who have occasional incontinence have the potential to be affected. All resident toileting plans will be reviewed by the care plan team and revised as needed. The nursing department has received education on the importance of following the toileting procedure and individual toileting plans of residents and the importance of documentation. DON or designee will perform random observation audits to ensure toileting plans are being followed. These audits will be completed two times a week for four weeks, then monthly for two months, then three quarterly for three quarters. Results of audits will be reported at the Quality Assurance Committee for further recommendations.	01/17/11

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 _____	12/08/2010

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 315	Continued From page 9	F 315		

of bladder and wears a pad . . . Needs extensive assist with toileting and toileting plan in place. Will express to staff need to be toileted but waits until last minute and at times incontinent . . ."

For this resident who is diagnosed with dementia, having to express the need to be toileted as identified in the above-stated urinary incontinence RAP, does not follow the facility's program for scheduled toileting which is defined as "timed toileting on a rigid fixed schedule and toileting takes place whether there is a sensation to void or not."

The current plan of care for Resident #3 in regard to urinary incontinence stated,
PROBLEM - "Alteration in bowel/urinary elimination R/T [related to] dementia M/B [manifested by] potential for constipation. Admitted with Nephritis [inflammation of one or both kidneys]. Occasional incont. [incontinence] of urine . . ."
GOAL - "Will be clean, dry & odor free thru 02/09/11 . . ."
APPROACH - ". . . Monitor for S/S's [signs & symptoms] of UTI [urinary tract infection] . . . Offer assist to toilet q [every] two hours and prn [as needed] during day and q 4 hours and prn at night. Total assist with all incontinent episodes."

Observations conducted on 12/07/10 and 12/08/10 identified facility staff did not implement Resident #3's toileting schedule as identified in the care plan. Observation of Resident #3 occurred on 12/07/10 from 7:40 a.m. - 11:45 a.m. and from 12:30 p.m. - 5:45 p.m.; and on 12/08/10 from 7:40 to 1:30 p.m. Observations during these time periods showed Resident #3 toileted two times:

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 _____	12/08/2010

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 315	Continued From page 10	F 315		

* 12/07/10 at 4:40 p.m. - continent when toileted.
* 12/08/10 at 8:55 a.m. - incontinent when toileted.

During an interview on on the morning of 12/08/10, an administrative nurse (#2) stated a Certified Nursing Assistant (CNA) had toileted Resident #3 on 12/07/10 between 11:45 a.m. and 12:30 p.m. when the resident was not being observed.

Review of Resident #3's urine voiding records occurred on 12/08/10. These voiding records showed the number of times the resident was toileted per day, the amount voided or the amount incontinent each time toileted, but lacked any times or time frames of when the resident was toileted. Therefore the facility lacks a means for knowing at what times, during a 24 hour period, toileting occurred for a resident. During interview, on the morning of 12/08/10, an administrative nurse (#9) verified there was no system "of knowing the times of day" when residents are toileted.

Review of Resident #3's urine voiding records between 11/29/10 and 12/05/10 showed facility staff failed to toilet this resident every two hours and as needed during the day as evidenced by:
* 11/29/10 - toileted 4 times in the 24 hour period and incontinent of urine 1 time
* 11/30/10 - toileted 5 times in the 24 hour period and incontinent of urine 2 times
* 12/02/10 - toileted 4 times in the 24 hour period and incontinent of urine 1 time
* 12/04/10 - toileted 3 times in the 24 hour period and incontinent of urine 1 time
* 12/05/10 - toileted 3 times in the 24 hour

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 _____	12/08/2010

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 315	Continued From page 11 period and incontinent of urine 0 times Facility staff failed to implement a consistent toileting schedule for Resident #3 to enable this resident to maintain her highest level of bladder continence.	F 315		
F 323 SS=E	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, hot water temperature readings, professional literature review, and staff interview, the facility failed to ensure the environment remained as free of accident hazards as possible in regards to safe water temperatures in 2 of 3 units (200 and 300 Units) of the facility. Very hot water places residents at risk for burns. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined standards of practice regarding hot water temperatures which states water may reach hazardous temperatures in hand sinks, showers, and tubs. Burns related to hot water/liquids may also be due to spills and/or immersion. Many residents in long-term care facilities have conditions that may put them at	F 323		

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 _____	12/08/2010

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 323	Continued From page 12 increased risk for burns caused by scalding. These conditions include: decreased skin thickness, decreased skin sensitivity, peripheral neuropathy, decreased agility (reduced reaction time), decreased cognition or dementia, decreased mobility, and decreased ability to communicate. Third degree burns can occur after five minutes of exposure to water at 120 degrees F (Fahrenheit), three minutes exposure at 124 degrees F, and one minute exposure at 127 degrees F. On 12/07/10 at 7:55 a.m., the water in the resident's hand sink was hot to the touch. When checked with a thermometer, the temperature of the water in the hand sink measured 131 degrees F. On 12/07/10 at 8:30 a.m., water temperatures taken in five random resident rooms on Unit 200 and 300, revealed the hot water temperatures exceeded 120 degrees F. The readings included the following: *Room 207 - 136 degrees F *Room 202 - 136 degrees F *Room 306 - 135 degrees F *Room 303 - 134 degrees F *Room 305 - 122 degrees F On 12/07/10 at 10:30 a.m., water temperatures taken in these rooms revealed the water temperatures remained higher than 120 degrees F with the following readings: *Room 208 - 134 degrees F *Room 207 - 132 degrees F *Room 202 - 134 degrees F *Room 306 - 132 degrees F *Room 303 - 131 degrees F *Room 305 - 131 degrees F	F 323	The thermostat at the water heater was turned down on Dec. 8, 2010. Water temperatures at the sink in room #s 207, 202, 306, 303, 305, and 208 will be monitored twice weekly for two weeks by the maintenance department. All resident rooms have the potential to be affected. The temperature at the water heater will be monitored weekly by the maintenance department. The water temperatures at the sink in three resident rooms will be checked weekly for three weeks to ensure temperatures are at acceptable levels, then one resident room weekly thereafter. Results of audits will be given to the Quality Assurance Committee for review and further recommendation.	01/17/11

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 _____	12/08/2010

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 323	Continued From page 13	F 323		

The maintenance staff member (#7) lowered the temperature setting for the water heater at noon on 12/07/10.

The environmental tour of the facility with a maintenance staff member (#7), administrative staff member (#16) and administrative housekeeping staff member (#8) occurred on 12/08/10 at 8:00 a.m. Observation of the temperatures gauge at the water heater revealed a temperature of 130 degrees F. Water temperatures taken with the staff member (#7) in four random resident rooms revealed the following hot water temperatures:
*Room 208 - 120 degrees F
*Room 202 - 125 degrees F
*Room 305 - 126 degrees F
*Room 306 - 121 degrees F

The maintenance staff member (#7) stated the temperature of the water to be too high and lowered the setting to the lowest possible setting on the water heater. The staff member stated he checked the temperature at the water heater daily and maintained the water heater temperature between 120 and 125 degrees F. The staff member stated he checked the water temperature at the hand sinks once a month or as needed and maintained the hand sink temperature between 120 to 123 degrees. The staff member (#7) did not maintain a record of these hand sink temperatures.

Review of the the temperature log for the water heater temperatures identified the temperature to be 130 degrees F on December 6-8, 2010. The readings for one or more water heaters exceeded 120 degrees daily for seven weeks prior.

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 _____	12/08/2010

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 323	Continued From page 14 During an interview on 12/08/10 at 11:00 a.m., a maintenance staff member (#7) agreed the water temperatures should be maintained less than 120 degrees F and monitored at the hand sinks in residents' rooms.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional literature, and staff interview, the facility failed to ensure adequate monitoring of medications for 1	F 329		

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 _____	12/08/2010

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 329	Continued From page 15 of 1 sampled resident (Resident #9) on an antiseizure medication. Failure to monitor for effective levels of Dilantin has the potential for the resident to have inadequate control of seizures or to become toxic. Findings include: "Nursing 2011 Drug Handbook," 31st ed., Lippincott, Williams, & Wilkins, Pennsylvania, page 573, states regarding phenytoin (Dilantin), "Indications & Dosages: To control tonic-clonic (grand mal) and complex partial (temporal lobe) seizures. . . . Nursing Considerations: . . . Monitor drug level. Therapeutic level is 10 to 20 mcg/ml (micrograms per milliliter). . . ." Review of Resident #9's medical record occurred on December 07-08, 2010. Diagnoses included seizures and dementia. Medications included Dilantin 100 mg [milligram] every a.m. and 200 mg every h.s. [bedtime]. A physician note, dated 04/07/10, stated, "Assessment and Plan: 1. Seizure onset. . . . We will continue Dilantin 100 mg in the am and 200 mg at hs and repeat a Dilantin level in a month's time. If that remains subtherapeutic I probably would boost that into the therapeutic range." A lab report, dated 05/06/10, revealed phenytoin level low at "1.8 ug/ml [micrograms per milliliter]" with the normal level of 10-20. An interdisciplinary progress note, dated 05/07/10 AM, indicated, "Dilantin level came back out of range 1.8. I faxed this to [name of physician] et [and] updated him on res [resident] not taking her meds [medications] x [times] 7 d [days]. Will await	F 329	Lab draw for resident #9 was completed on Dec. 9, 2010. Dilantin levels were evaluated, medication was changed and a schedule for lab draws was made. All residents that have orders for Dilantin have the potential to be affected. Only resident #9 receives Dilantin at this time. DON or designee will review lab schedules for these residents and monitor the results. Physician will be contacted as needed and follow up completed. Education for the nurses was completed on Dec. 16, 2010 on the importance of adequate monitoring of Dilantin levels and follow up with the physician. DON or designee will perform audits to ensure lab draws for therapeutic levels of Dilantin were completed according to schedule and were followed up on. The audit will be completed weekly for two weeks, then three times monthly for three months,	01/07/11

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 _____	12/08/2010

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 329	Continued From page 16 any return orders." The record failed to show evidence of further orders regarding the subtherapeutic Dilantin level or additional efforts of the staff to contact the physician. During an interview on 12/08/10 at 12:05 p.m., an administrative nurse (#2) agreed staff should have followed up with the physician on the low Dilantin level. During an interview on 12/08/10 at 1:40 p.m., a physician (#5) stated both he and nursing staff missed following up on the low Dilantin level, and he planned to order a Dilantin level now.	F 329	then one time quarterly for three quarters. Results of audits will be given to the Quality Assurance Committee for review and further recommendation.	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the facility failed to store potentially hazardous foods in a safe and sanitary manner in 3 of 5 residents' (Resident #5, #12, and #13) personal refrigerators observed in the facility. This practice placed residents, who eat food stored in these personal refrigerators, at	F 371		

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 _____	12/08/2010

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 371	Continued From page 17 risk of food borne illness. Findings include: The facility's policy, "Resident's Kitchen Electrical Appliances," stated, " . . . 1. Expectations of family/resident . . . h. Label, date, and cover all foods that are brought in for the resident. . . . 3. Expectations of the center . . . c. The director of dietary services (DDS) will . . . routinely check for compliance with the above expectations. . . ." Observation of personal refrigerators, located in residents' rooms, occurred on 12/06/10 at 2:50 p.m. during the initial facility tour. The refrigerators contained the following items: * Resident #12's refrigerator: a chicken breast on a dried bun and egg salad on a croissant each wrapped in napkins. The items lacked a date identifying when the resident had stored the items. The napkins wrapped around the sandwiches were wet to the touch from moisture dripping from a heavy ice build up on the refrigerator's freezer compartment. A shelf in the refrigerator's door contained half a tuna sandwich stored in a small plastic bag, labeled with the number "20." * Resident #13's refrigerator: a sixteen ounce plastic container of ham and bean soup. The item lacked a date identifying when the resident had stored the item. * Resident #5's refrigerator: 3, four ounce glasses of chocolate milk. The items lacked a date identifying when the resident had stored the items. The freezer compartment of the refrigerator contained 10, four ounce cups of ice cream, which appeared to have thawed and refrozen.	F 371	The contents of the personal refrigerators in resident rooms of #5, #12 and #13 were inspected, all expired items were removed and the freezer compartments were defrosted. All residents who have a personal refrigerator in their room have the potential to be affected. Residents and families have been educated on proper procedures for maintaining the refrigerator and the importance food safety. Dietary manager or designee will check fridges on a weekly basis, remove expired items, ensure that items are in proper containers and look for ice build up in the freezer compartments. Dietary manager or designee will defrost freezer compartments as needed. Dietary manager or designee will perform audits on resident personal refrigerators to ensure proper procedures are being followed. Three refrigerators will be checked monthly for three months, then three fridges quarterly for three quarters. Results of audits will be given to the Quality Assurance Committee for review and further recommendation.	01/17/11

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 _____	12/08/2010

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 371	Continued From page 18 Observation of these personal refrigerators on the afternoon of 12/07/10 and morning of 12/08/10 with an administrative dietary staff member (#6) and interview of this staff member on the morning of 12/08/10, confirmed the items remained stored in the refrigerators. The staff member discarded the items in Resident #12's and Resident #5's refrigerator and agreed the freezer compartment in Resident #12's refrigerator needed to be defrosted. The staff member identified the "20," as the day dietary staff prepared the sandwich but could not identify the month when a staff member prepared the sandwich. Interview of the staff member (#6) on 12/08/10 at 11:05 a.m., identified she had visited with Resident #13's family member and he could not identify the date he had placed the soup in the resident's refrigerator. The family member removed the soup from the resident's refrigerator. Interview of an administrative dietary staff member (#6) occurred on the afternoon of 12/07/10. The staff member stated she does not check food in personal refrigerators on a scheduled basis. She confirmed some residents are not complying with the facility policy. She identified she had not checked Resident #12's personal refrigator for probably three weeks or more. This staff member agreed facility staff should monitor the storage of potentially hazardous foods in residents' personal refrigerators for length of storage and the refrigerators' freezer compartments for ice buildup.	F 371		
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	F 441		

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 _____	12/08/2010

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 441	Continued From page 19 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 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, record review, review of facility policy, and staff interview, the facility failed	F 441	The box of gloves in resident #10's room has been discarded. Residents #3 and #10 show no signs or symptoms of infection from not following proper infection control procedures and are currently receiving cares using our hand hygiene procedure. All residents have the potential to be affected by this. Education for the nursing department on the proper use of gloves and hand hygiene was completed. DON or designee will perform four random observation audits to ensure proper use of gloves and hand washing. The audit will completed weekly for four weeks, monthly for two months, then quarterly for three quarters. Results of audits reported to the Quality Assurance Committee for review and further recommendation.	01/17/11

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 _____	12/08/2010

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 441	Continued From page 20	F 441		

to follow infection control practices for 2 of 5 sampled residents (Resident #3 and #10) observed during perineal cares. Failure to follow infection control practices has the potential to spread infection within the facility.

Findings include:

Review of a facility policy titled "Hand Hygiene and Handwashing" occurred on 12/08/10. This policy, revised on July 2009, stated, ". . . If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning your hands: . . . After having direct contact with a resident's skin . . . After removing gloves"

- Review of Resident #10's medical record occurred on 12/08/10. The resident's significant change Minimum Data Set (MDS), dated 11/10/10, identified the resident required total assistance by staff for personal hygiene.

Observation on 12/08/10 at 9:45 a.m., showed Resident #10 laying on her bed while the CNAs (#3 and #4) applied gloves and checked her brief. The CNA (#3) identified the brief as wet and proceeded to remove the brief with the assistance of the other CNA (#4). The CNA (#4) cleansed the resident's buttocks, applied a protective cream, and removed her soiled gloves. The CNA (#4) reached into the glove container, dropped a third glove on the floor, picked it up, and placed it back into the container with the remaining clean gloves. After putting on a new pair of gloves, the CNA (#4) provided pericares and applied more of the protective cream. Both CNAs (#3 and #4) adjusted Resident #10's clothing, removed their soiled gloves, and utilized a full body mechanical

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 _____	12/08/2010

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 441	Continued From page 21	F 441		

lift to transfer the resident from her bed to the wheelchair. Both CNAs (#3 & #4) failed to wash or sanitize their hands after providing pericares and/or removing their soiled gloves.

During an interview on the morning of 12/08/10, an administrative nurse (#2) agreed facility staff did not follow proper infection control practices, and should have cleansed their hands after removing their gloves.

- Observation showed two CNAs (#3 and #4) assisted Resident #3 with toileting in her bathroom on 12/08/2010 at 8:55 a.m. The CNAs transferred the resident to the toilet and removed Resident #3's incontinent brief, wet with urine. One CNA (#4) applied clean disposable gloves, wiped the resident's perineal and rectal area, removed her soiled gloves, assisted with transferring the resident into her wheelchair, put on clean gloves, and then assisted the resident with oral cares. The CNA failed to perform hand hygiene after removing her soiled gloves used when cleansing the resident's perineal and rectal area.

During an interview on the morning of 12/08/10, an administrative nurse (#2) confirmed facility staff should perform hand hygiene after removing soiled gloves.