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 _____	12/09/2015

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

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on December 7, 2015 and completed on December 9, 2015, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278		1/13/16

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

Electronically Signed | 12/23/2015

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F 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the residents' status for 4 of 9 sampled residents (Resident #1, #3, #4, and #5) reviewed regarding turning/repositioning schedule, hypnotic medication use, nutrition related to skin healing, and restraint use. Failure to correctly code items on the MDS does not provide an accurate assessment of the resident's current status. Findings include: The Long-Term Care Facility RAI User's Manual, October 2015, stated the following: * Page M-38 (M1200C Turning/Repositioning Program), "The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours)." * Page M-38 (M1200D Nutrition or Hydration Intervention to Manage Skin Problems), ". . . nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. . . ." * Page N-6 (Medications), "Code medications in Item N0410 according to the medication's therapeutic category and/or pharmacological classification, not how it is used."	F 278	Section P0100G of the quarterly MDS for Resident #1 has been modified to identify the wedge cushion as a restraint and the MDS was been sent to the state and CMS on 12/17/15. Section M1200C of the quarterly MDS for Resident #3 has been modified to remove the individualized turning and repositioning schedule and was sent to the state and CMS on 12/18/15. Section N0410 of the annual MDS for Resident #5 has been modified to remove hypnotic medication and was sent to the state and CMS on 12/18/15. Section M1200C of the Medicare 30 Day MDS, dated 11/2/15 and the significant change MDS, dated 10/12/15 for Resident #4 have been modified to remove the individualized turning and repositioning schedule. Section M1200D has been modified to remove the individualized nutritional assessment. The modified MDS□'s were sent to the state and CMS on 12/18/15. All residents with restraints and all residents that use hypnotic medications have the potential to be affected. Sections P0100G and M1200C on the current MDS□'s of these residents were reviewed	

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F 278	Continued From page 2 * Page P-1 - P-6 (Physical restraints), "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, which restricts freedom of movement or normal access to one's body. . . . Chairs that prevent rising . . . Chairs that have a cushion placed in the seat that prohibit the resident from rising. . . ." - Review of Resident #1's medical record occurred on all days of survey. The resident's care plan, dated 05/28/15, stated "The resident uses physical restraints R/T [related to] fall risk wedge cushion used. . . .wedge cushion when in wheelchair. . . ." A physician order, dated 04/16/15, stated "Wedge cushion in wheelchair to maximize safety every shift for safety." The resident's quarterly MDS, dated 11/24/15, failed to identify a chair that prevents rising restraint used daily at P0100G. During an interview, on 12/09/15 at 9:55 a.m. and 1:54 p.m., an administrative nurse (#1) and a licensed nurse (#2) identified the wedge cushion used by Resident #1 is a restraint. - Review of Resident #3's medical record occurred on all days of survey. The resident's quarterly MDS, dated 09/11/15, identified a turning and repositioning schedule. The resident's current care plan stated, "Focus . . . has potential for alteration in skin R/T decrease mobility and incontinence . . . Interventions . . . Turn and reposition in bed Q [every] 2 hours . . ." The facility failed to implement an individualized,	F 278	to ensure the coding is accurate. All residents that have individualized turning and repositioning schedule and/or individualized nutritional assessment checked on the MDS have the potential to be affected. Sections M1200C and M1200D of the current MDS'□s of all residents will be audited by the DON or designee. The MDS'□s that have either individualized turning and repositioning schedule and/or individualized nutritional assessment checked on the MDS will evaluated for accuracy and to ensure that supporting documentation is in place. If the coding is inaccurate on any of the MDS'□s, the MDS will be modified and re-submitted to the state and CMS. The Care Plan team will receive education on coding the MDS sections P0100G, M1200C, M1200D, and N0410 on 1/05/2016. Audits on sections P0100G, M1200C, M1200D, and N0410 of the MDS□s of 8 residents will be conducted monthly for 3 months by the DON or designee to ensure coding accuracy. Results of the audits will be reviewed by the QA committee for recommendations and/or follow-up.	

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F 278	Continued From page 3	F 278		

resident-specific turning and repositioning program for Resident #3.

- Review of Resident #5's medical record occurred on all days of survey. The resident's annual MDS, dated 09/20/15, identified a hypnotic medication. Review of Resident #5's current list of medications identified Tylenol PM, a medication for pain that also promotes sleep, but is not classified as a hypnotic medication.

- Review of Resident #4's medical record occurred all days of survey. The resident's Medicare 30 day MDS, dated 11/2/15, and significant change MDS, dated 10/12/15, identified a turning and repositioning schedule. The significant change MDS also identified nutrition or hydration interventions to manage skin problems. The resident's current care plan stated, "Focus . . . The resident has an ADL [activities of daily living] self care performance deficit R/T dementia E/B [evidenced by] needs assist. Returned from hospital left hip fx [fracture] . . . Interventions . . . reposition q 2 hours. . . ."

The facility failed to implement an individualized, resident-specific turning and repositioning program for Resident #4 and failed to complete an individualized nutritional assessment to determine the need for nutrition and/or hydration interventions for the purpose of preventing or treating specific skin conditions during the assessment period.

During an interview on 12/09/15 at 4:38 p.m., an administrative nurse (#2) indicated the facility had a standard turning schedule. The nurse (#2) confirmed the facility failed to develop an

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F 278	Continued From page 4 individualized specific turning schedule for Resident #3 and Resident #4.	F 278		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		1/13/16

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F 431	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure medication vials were accurately labeled for 2 of 3 sampled residents (Resident #13 and #14) receiving insulin. Failure to notify the resident's pharmacy when a medication label does not match the prescription and failure to obtain the correct medication label increases the risk of error and has the potential for the resident to receive an incorrect dose of medication. Findings include: - Observation on 12/07/15 at 4:49 p.m., showed a licensed nurse (#3) prepared Resident #13's medication. The nurse drew up 10 U [units] of Novolog insulin into a syringe. The pharmacy label affixed on the vial stated "Novolog Solution Inject subcutaneously 14 U at 7:30 a.m. and 11:00 a.m., give 10 U at 5 p.m." Review of Resident #13's medical record occurred on 12/08/15. A physician order, dated 07/21/14, stated, "Novolog Solution Inject 10 unit subcutaneously three times a day for DM [Diabetes Mellitus] related to Diab [Diabetes] w/o [with out] comp [complication] Type II/ UNS [unspecified] NOT STATED UNCNTRL[Uncontrolled]." - Observation on 12/07/15 at 4:45 p.m., showed a licensed nurse (#3) prepared medication for Resident #14. The nurse drew up 10 U of Novolog insulin. The pharmacy label affixed on the vial stated "Novolog Solution Inject	F 431	Labels on the insulin vials for Residents #13 and #14 have been updated by the pharmacist. All residents that have insulin prescribed have the potential to be affected by an inaccurate label. All current residents receiving insulin had their insulin vials audited to ensure the labels matched the physician order. All licensed nurses will receive education on the procedure for acquiring, receiving, and dispensing insulin on January 7, 2016. Audits on 5 insulin vials will be conducted monthly for 3 months by the DON or designee to ensure that the label matches the current physician orders. Results of the audits will be reviewed by the QA committee for recommendations and/or follow-up.	

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F 431	Continued From page 6 subcutaneously 10 units TID [three times daily]." Review of Resident #14's medical record occurred on 12/08/15. A physician order stated, "Novolog Solution Inject subcutaneously 10 U before meals AND Inject 10 U subQ [subcutaneously] as needed for DM. Give 10 U subQ after brunch if she eats brunch." The facility failed to update the labels to reflect the updated physician order. During an interview on 12/09/15 at 11:00 a.m., an administrative nurse (#1) agreed that the labels were incorrect according to the physician order.	F 431		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain complete and accurate clinical records for 1 of 9 sampled residents	F 514	We are unable to correct the documentation for Resident #6 due to the time that has lapsed since the incident.	1/13/16

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F 514	Continued From page 7 (Resident #6). Failure to ensure a complete medical record does not allow staff and/or providers to have access to all information necessary to provide care and treatment for the residents. Findings include: Review of Resident #6's medical record occurred on December 7-9, 2015. Documentation in the resident's chart identified the following: * Occupational Therapist note, dated 06/09/15, ". . . asked by facility to complete motorized wheelchair assessment as Resident had collided into another person while driving motorized scooter and did not recall the incident. . . ." * Consultant progress note, dated 07/06/15, ". . . She [the resident] talks about having a motorized wheelchair being removed. She states that she slightly bumped into someone, it was an accident, and, therefore, she can not longer use her motorized wheelchair. . . ." Resident #6's medical record lacked documentation describing the incident referred to by occupational therapy and the consultant. During an interview, on 12/09/15 at 3:30 p.m., an administrative nurse (#1) identified they could not locate documentation describing the incident identified by the occupational therapist and the consultant.	F 514	The Rehab Coordinator has reviewed the documentation on all residents that are currently receiving services from a licensed therapist to ensure that there is adequate documentation in place. All residents that are referred to a licensed therapist have the potential to be affected. An assessment and a progress note will be completed before a referral is given to a licensed therapist. The Rehab Coordinator or designee will review the documentation before making the referral. All licensed nurses will receive education on the procedure for referring a resident to a licensed therapist which includes the use of an assessment and a progress note on 01/07/2016. The Rehab coordinator or designee will audit all new referrals to a licensed therapist monthly for 3 months to ensure compliance with the referral procedures. Results of the audits will be reviewed by the QA committee for recommendations and/or follow-up.	