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 _____	12/01/2011

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 recertification survey started on November 28, 2011 and completed on December 1, 2011, the sample included two residents for complete review, eight residents for focused review, and 1 closed record for review.	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/or executed solely because it is required by the provisions of Federal and State Law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: 1. Based on record review, policy and procedure review, and staff interview, the facility failed to assess resident behaviors for causative/precipitating factors, develop and implement specific and individualized interventions, monitor the effectiveness of these interventions, and revise them accordingly for 1 of 1 sampled resident (Resident #2) identified by the facility as exhibiting resident to resident aggressive behavior. Failure to assess behaviors, implement interventions, and monitor resident response to interventions does not allow for planning and implementation of interventions to prevent/minimize the occurrence of aggressive behaviors and has the potential for residents to injure each other. Findings include:	F 250		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rita J. Coffey — TITLE: Administrator — (X6) DATE: 12-26-11

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 _____	12/01/2011

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 250	Continued From page 1 Review of the facility's "Behavior Management Committee" policy occurred on the morning of 12/01/11. The policy, dated September 2010, stated, "A Behavior Management Committee is formed to analyze the root cause(s) of a resident's behavior as well as provide alternatives to staff for solutions. It is designed as an interdisciplinary vehicle using the talents of staff across all shifts and disciplines . . . focuses on the identified treatment and evaluation of behaviors. Information and plans generated from this meeting will be used to update care plans on these residents on a more frequent basis than the traditional quarterly care plan. . . .The social worker is considered to be the lead person in developing and promoting the concept of this committee and coordinating its actions . . . Mood and behavior symptoms as well as causes, interventions and outcomes are documented in the Mood/Behavior module on the handheld [computerized certified nursing assistant (CNAs) charting]. All interventions coded with responsible party of BEH [behavior] in the Resident Services Care Planning module will automatically pull to the handheld. Starting the approach with the target behavior . . . can be helpful to pinpoint the type of intervention that staff should use for a specific mood or behavior symptom . . . ." During an initial tour of the facility on 11/28/11 at 6:30 p.m., an administrative nursing staff member (#4) identified Resident #2 as verbally aggressive towards other residents and identified three residents he targeted. During a family interview on 11/29/11 at 3:35 p.m., a family member (#1) confirmed Resident #2 had negative verbal interactions with two	F 250	Resident #2 is being monitored for a period of 10 days to trend behaviors. The care team will use the information to update the care plan and EHR with interventions for aggressive behavior. All residents with resident to resident aggressive verbal behaviors have the potential to be affected. All residents that trigger on question E200B in section E on the MDS will be monitored for a period of 10 days to determine patterns in behavior. The care team will use the information to update the care plans and EHR's with interventions. All residents that have recently experienced death in the family have the potential to be affected. The care team will update the care plans and EHR's to include grieving process interventions. Nursing and social service staff will receive re-education on the hand held Mood and Behavior modules and the procedure of Behaviors Causes and Interventions.	01/05/12

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 _____	12/01/2011

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 250	Continued From page 2 residents. Review of Resident #2's medical record occurred on November 29 - December 1, 2011. The resident's diagnoses included dementia, anxiety, and depression. Resident #2's interdisciplinary progress notes (IDPs), from August - November 2011, identified the resident exhibited behaviors of: *08/23/11 at 10:30 a.m. - "Told her to shut up and keep her . . . mouth shut . . . and if she didn't keep it shut he was going to hit her and he raised his Rt [right] arm [with] a fist as he threatened her. . . ." *09/07/11 at 10:00 p.m. - "Stated . . . he was going to hit her to shut her up . . . ." *09/08/11 at 7:30 p.m. - "Another resident commented as he approached 'There's that mean man, don't you think that man is mean, he scares me' This is a regular occurrence [sic] [Resident #2's name] has become increasingly verbally aggressive towards this resident at times threatening to slap her in the mouth. . . ." *09/16/11 at 8:00 p.m. - " . . . raised his hand as to 'back hand' her in the mouth . . . He said 'I'm going to hit her in the mouth, you can't always be around . . .'" *10/08/11 at 12:20 p.m. - "Resident was in the hallway yelling at another resident . . . He told her to shut her mouth several times, Med [medication] nurse heard him . . . say 'I am going to knock your . . . head off.' Nurse took the other Resident [resident's room number] away. . . ." *10/21/11 at 8:45 p.m. - ". . . walked right up to [resident's initials], stood over her and stated 'shut the hell up or I'm gonna hit you.'" *11/07/11 at 11:20 p.m. - "Res [resident] arguing	F 250	Social worker or designee will audit 3 charts monthly for two months and then audit 3 charts quarterly for the next three quarters to ensure that aggressive behaviors and family deaths have been addressed. Results of audits will be reported at the Quality Assurance Committee for further recommendations.	

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 _____	12/01/2011

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 250	Continued From page 3 [with] other Res [resident's initials] at NS [nurses' station] Res yelling . . . 'Shut the hell up.'" *11/12/11 at 2:00 p.m. - " . . . Resident upset with another resident and lifted his hand to her, states, 'You never say anything nice. It's always negative. Keep your mouth shut.'" *11/28/11 at 1:20 p.m. - ". . . res stated, 'Just leave me alone.' This res talked back. . . . " The interdisciplinary progress notes lacked consistent identification of targeted residents for assessment, monitoring, and implementation of interventions to prevent/minimize further resident directed behavior. Resident #2's "Mood and Behavior" Reports for January - November 2011, compiled from computerized CNA charting failed to identify aggressive verbal resident to resident behavior. Resident #2's current care plan stated the problem of "Alteration in Behavior r/t [related to] dementia and anxiety m/b [manifested by] at risk for elopement and wanders" with no interventions identified for Resident #2's threatening verbal behavior toward other residents. Resident #2's social service progress notes stated: *11/04/11 - ". . . has had no changes for activities or social services. He is approachable and friendly, interacts well with most peers and staff as observed during activities of choice, meals and social times . . . Alteration in behavior; resident continues to have behaviors, staff reinforces goals and plans and approaches will continue . . . " *11/11/11 - "Resident has had no changes for this department since prior assessment. Please refer	F 250		

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 _____	12/01/2011

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 250	Continued From page 4 to note dated 11/04/11." The social services progress notes lacked an assessment and interventions related to Resident #2's threatening behavior toward other residents. Review of the behavior committee meeting minutes regarding Resident #2 revealed: *08/17/11 - "Discussion/Conclusions: . . . Has conflict with female resident. Action Plan/Recommendations: . . . This is not being charted in HER [sic] EHR [electronic health record] *09/21/11 - "Discussion/Conclusions: Had one day of behaviors during the month. Action Plan/Recommendations: It was determined to monitor this resident for another 60 days to see if there are further instances." *10/19/11 - "Discussion/Conclusions:. . . had only one day of behaviors on the EHR, however he has had multiple behaviors charted in the IDP's. The group held a discussion about what could be done. Action Plan/Recommendations: [Listing of activities] Develop a behavior plan for care plan." Review of Resident #2's care plan lacked a behavior plan for resident to resident behavior. *November Behavior Meeting Minutes were not completed/available for review when requested on the morning of 12/01/11. The behavior committee failed to analyze the root cause of Resident #2's behavior and implement appropriate interventions. During an interview on 12/01/11 at 10:00 a.m., a social services staff member (#3) stated the behavior committee meets once a month. This staff member stated residents involved were not consistently identified in the interdisciplinary progress notes regarding behaviors. The social	F 250		

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 _____	12/01/2011

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 250	Continued From page 5 services staff member (#3) agreed facility staff are "not tracking and trending [resident behaviors]."The staff member stated the behavior has to be included on the care plan in order for CNAs to chart the behavior for the computerized mood and behavior reports. The social services staff member (#3) had not assessed and identified specific intervention to minimize/prevent Resident #2's threatening verbal behavior directed at other residents. 2. Based on record review and staff interview, the facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 2 sampled residents (Resident #6) who experienced the recent loss of a child. Failure to probe for signs/symptoms (s/s) of depression or grieving in a resident described as "stoic" by staff and provide individual support, interventions, or counseling may have contributed to emotional distress and restarting of an antidepressant. Review of Resident #6's medical record occurred on November 29 - December 1, 2011. Diagnoses included depression secondary to chronic pain. Resident #6's quarterly Minimum Data Set (MDS), dated 08/24/11, indicated the resident as cognitively intact. Resident #6's Interdisciplinary Progress notes stated the following: * 07/09/11 at 2:00 p.m. - ". . . teary eye when speaking about daughter, states 'It's really hard to see her like that, before I came here we were always together. I never left her alone. I know	F 250		

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 _____	12/01/2011

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 250	Continued From page 6 she'll be in a better place. . . ." * 07/14/11 at 8:30 a.m. - ". . . Resident out for funeral for her daughter [with] her family." * 07/18/11 at 8:00 a.m. - ". . . Resident seems to be handling the death of her daughter last week et [and] 'feels it was for the best as she has been ill for a long time' . . ." * 11/23/11 at 1:00 p.m. - ". . . Resident's daughter, [name of daughter] told writer that Resident was weeping today. Sad about her husband and daughter not being here during the holidays. Her daughter passed away this past July. Also, [name of daughter] said she is having hip pain - Resident does not complain about pain to staff . . . very stoik [sic]. [Name of doctor] spoke [with] her [resident] and visited about the death of her husband [and] daughter. . . ." Resident #6's physician recertification notes stated the following: * 07/27/11 - "No complaint of depression, last 12/2010 decreased Citalopram [an antidepressant] 10 mg every A.M. - plan decrease and dc [discontinue] Citalopram." * 09/21/11 - "She is not sleeping well. We talked about death of her daughter on July 2011. Patient still grieving. Patient off Citalopram now, need to watch for depression." * 11/23/11 - Citalopram restarted per physician order. Review of the "Behavioral Symptoms/Mood" section on the monthly nursing documentation form from 07/04/11 through 11/04/11 indicated Resident #6 with "no mood changes" and "coping well." During an interview on 12/01/11 at 10:35 a.m., a licensed nurse (#5) agreed with the above documentation, but added the resident "is very	F 250		

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 _____	12/01/2011

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 250	Continued From page 7 stoic, and wouldn't complain even of severe pain." Resident #6's current careplan stated "Problems/Needs/Concerns: Potential for alteration in mood R/T dx [diagnosis] of depression . . . Plans and Approaches: Notify CN [charge nurse] of any changes in mood or behavior . . . Meds as ordered . . . SS [Social Services] 1:1 [one to one] visits prn [as needed] to monitor mood state & to allow resident to vent feelings & concerns . . ." Review of the Social Services Quarterly Notes for Resident #6 revealed the following: * 06/02/11 - "[Name of resident] has had no changes for this department during the assessment period. . . . Alteration in mood state; she has no s/s of depression . . ." * 08/26/11 - "[Name of resident] has had no changes for this department. . . . Alteration in mood state; she is meeting her goals, plans and approaches will continue. . . ." *11/23/11 - ". . . she has had no changes for this department during the assessment period. . . . Alteration in mood state; she is meeting her goals, plans and approaches will continue. . . ." Resident #6's medical record failed to show involvement from Social Services related to her daughter's illness and death, any indication of a discussion, follow-up, or 1:1 visits with the resident related to coping with her daughter's death, or interventions put in place during the daughter's illness and following her death. During an interview on 12/01/11 at 10:55 a.m., a social services staff member (#3) stated, "I	F 250		

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 _____	12/01/2011

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 250	Continued From page 8 haven't seen any s/s of depression" when asked about Resident #6's coping with her daughter's death and the doctor's order to restart an antidepressant. The staff member indicated she monitors for depression through the resident's interaction with others, participation in Activities, and arranges for the resident to talk to her pastor, if desired. When asked about the lack of the resident's daughter's death on the care plan, the social services staff member stated, "Normally I do add a death in the family to the care plan and thought I had." The staff member added, "I talk to residents every day and don't often document, unless it is a formal 1:1."	F 250		
F 280 SS=E	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.	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 _____	12/01/2011

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 9 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 12/08/10. Based on record review, review of facility policy, and staff interview, the facility failed to review and revise the care plan for 4 of 10 sampled residents (Resident #1, #2, #3, and #6). Failure to evaluate and revise the care plan periodically or as the residents' status changes has the potential to affect staff's understanding of the residents' problems/concerns and required interventions, limits staff's ability to communicate resident care issues, and may lead to lack of/or inconsistency in cares. Findings include: Review of facility policies and procedures occurred on November 30-December 1, 2011. A facility policy titled "Elopement," revised 01/11, stated, "PURPOSE. To assess and identify residents at risk of elopement. To clearly define the mechanisms and procedures for monitoring and managing residents at risk for elopement. . . . DEFINITION. Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. PROCEDURE. . . . 4. Care plan team members should consider the following when assessing risk of elopement: a. wandering behavior. . . . Unsafe wandering and elopement can be associated with falls and related injuries. . . ." 8. Residents who attempt elopement after admission: . . . 9. Sample care plan: Problem. Potential for elopement r/t [related to] . . .	F 280	Resident #1 is being monitored for a period of 10 days to trend wandering. The MDS nurse will establish an individualized toileting plan; update the care plan and the EHR. The social worker will complete an Elopement Risk Assessment and update the care plan as necessary. Resident #2 is being monitored for a period of 10 days to trend behaviors. The care team will use the information to update the care plan and EHR with interventions as necessary. Resident #3 passed away on Dec. 11. Resident #6's care plan has been updated to include the death of her daughter. Social service will one on one resident monthly for 3 months and chart in the IDP notes. Care plan and EHR will be updated as necessary. All residents have the potential to be affected. The care team will review all resident charts to ensure that all current medical and psychosocial concerns have been addressed. Care plans and EHR will be updated as necessary.	01/05/12

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 _____	12/01/2011

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 10 wandering behavior, elopement attempts . . ." - Record review for Resident #1 occurred on November 28-December 1, 2011. The facility admitted the resident on 04/12/11 with diagnoses of Alzheimer's dementia, osteoporosis, and urinary frequency. Resident #1's admission Minimum Data Set (MDS), dated 04/18/11, and quarterly MDS, dated 10/15/11, identified Resident #1 with short and long term memory problems and severe cognitive impairment. Resident #1's "Pre-Admission Case Management Data" assessment, dated 04/12/11 (day of admission), identified no wandering or history of elopement; however, a note on the assessment form, stated, "Wandering risk at [prior facility]. Do not know how she will do in a new place." Review of Resident #1's current comprehensive care plan identified the following: "Alteration in behavior R/T [related to] dementia . . . wandering into other residents' rooms to toilet. . . . assess for toileting needs and toilet as needed. Monitor whereabouts throughout shift. Document all behavior incidents. . . ." The resident's toileting plan showed the following: "Alteration in bowel/urinary elimination R/T . . . dementia . . . history of urinary frequency. . . . Offer toileting upon rising, before brunch, following afternoon nap, before supper, at bedtime and Q [every] 4 HRS [hours] during NOC [night] and PRN [as needed]." Review of Resident #1's interdisciplinary notes identified wandering behavior present starting in July of 2011. The notes showed the following:	F 280	The care team will review all resident care plans on a quarterly basis to ensure that all medical and psychosocial concerns are being addressed. Education with the nurses and the care team on the review and revision of care plans will take place. The social worker or designee will audit 4 charts monthly, then 4 charts quarterly for 3 quarters to ensure the care plans reflect the current status of the resident Results of audits will be reported at the Quality Assurance Committee for further recommendations.	

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 _____	12/01/2011

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 11 * 07/22/11- Resident #1 wandered into two separate resident's rooms to use the bathroom. The residents became upset and began yelling. * 08/14/11- wandered into another resident's room to use the bathroom. * 08/21/11- exited the east door of the building and walked to the end of the sidewalk. Entered the building per self in the presence of a supervising staff member. Later that evening, staff observed the resident exiting another resident's bathroom after using it. * 08/23/11- wandered into another resident's room to use the bathroom. * 09/04/11- wandered into a resident's room to use the bathroom. * 09/10/11- indicated the resident needed supervision and re-direction if wandering down the wrong hallway. The medical record lacked evidence facility staff tracked the resident's wandering, consistently documented the wandering behavior, or re-assessed the resident's current toileting plan to determine if a more individualized toileting plan would prevent Resident #1 from using other residents' bathrooms for toileting. The record further lacked an elopement risk assessment following the incident on 08/21/11, in which Resident #1 exited the building. Resident #1's current care plan lacked interventions in place to address Resident #1 exiting the building on 08/21/11, or to prevent	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 _____	12/01/2011

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 12	F 280		

future episodes of exit seeking. The resident's current care plan lacked evidence of a specific, individualized toileting plan to address wandering into other residents' bathrooms to toilet.

- Review of Resident #2's medical record occurred on November 29 - December 1, 2011. The resident's diagnoses included dementia, anxiety, and depression.

Review of Resident #2's interdisciplinary progress (IDP) notes showed verbally aggressive/threatening behaviors directed towards other residents in the months of August, September, October, and December.

Resident #2's current care plan stated the problem of "Alteration in Behavior r/t [related to] dementia and anxiety m/b [manifested by] at risk for elopement and wanders" with no interventions identified for Resident #2's threatening verbal behavior toward other residents.

During an interview on the morning of 12/01/11, an administrative nursing staff member (#2) and a social services staff member (#3) confirmed interventions for Resident #2's threatening verbal behavior toward other residents should be included in the resident's plan of care to prevent potential injury to Resident #2 or other residents.

- Review of Resident #3's medical record occurred on November 29 - December 1, 2011. The facility admitted the resident in June 2011. The resident's diagnoses included anxiety, amyotrophic lateral sclerosis (ALS), and mild pharyngeal dysphagia. The resident's quarterly

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 _____	12/01/2011

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 13	F 280		

Minimum Data Set (MDS), dated 09/21/11, identified the resident as having a Brief Interview for Mental Status (BIMS) score of 15 indicating cognitively intact; requiring extensive assistance with dressing, toileting, and personal hygiene, and bathing; and supervision with eating.

Resident #3's IDP notes revealed the following:
*09/13/11 - "Resident would prefer female caretaker to do her cares and toilet her. Will inform staff."
*06/27/11 - ". . . No use of straws . . ."

Review of Resident #3's Medication Administration Record identified within Special Instructions "no straws."

Review of Resident #3's dietary card, during the dietary tour on 12/01/11 at 8:00 a.m., identified no "straws."

Resident #3's current care plan failed to address Resident #3's preference for female caretakers and the use of "no straws" with beverages.

During interviews on the morning and afternoon of 12/01/11, an administrative nursing staff member (#2) confirmed Resident #3's preference for a female caretaker and no use of straws with beverages should be included in her plan of care.

- Review of Resident #6's medical record occurred on November 29 - December 1, 2011. Diagnoses included depression secondary to chronic pain.

Resident #6's IDP notes stated the following:
* 07/09/11 at 2:00 p.m. - ". . . teary eye when

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 _____	12/01/2011

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 14	F 280		

speaking about daughter, states 'It's really hard to see her like that, before I came here we were always together. I never left her alone. I know she'll be in a better place. . . ."
* 07/14/11 at 8:30 a.m. - ". . . Resident out for funeral for her daughter [with] her family."
* 11/23/11 at 1:00 p.m. - ". . . Resident's daughter, [name of daughter] told writer that Resident was weeping today. Sad about her husband and daughter not being here during the holidays. Her daughter passed away this past July. . . ."

A physician recertification note, dated 09/21/11, stated "She is not sleeping well. We talked about death of her daughter on July 2011. Patient still grieving. Patient off Citalopram now, need to watch for depression." On 11/23/11, the physician restarted Resident #6's Citalopram.

Resident #6's current careplan stated "Problems/Needs/Concerns: Potential for alteration in mood R/T dx [diagnosis] of depression . . . Plans and Approaches: Notify CN [charge nurse] of any changes in mood or behavior . . . Meds as ordered . . . SS [Social Services] 1:1 [one to one] visits prn [as needed] to monitor mood state & to allow resident to vent feelings & concerns . . ." Resident #6's care plan lacked any indication of her daughter's illness/death and interventions to support the resident during this difficult time.

During an interview on 12/01/11 at 10:55 a.m., when asked about the lack of Resident #6's daughter's death on the care plan, a social services staff member (#3) stated, "Normally I do add a death in the family to the care plan and

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 _____	12/01/2011

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 15 thought I had."	F 280		
F 323 SS=D	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 professional reference, review of facility policy and procedure, record review, and staff interview, the facility failed to ensure an environment free of accident hazards for 1 of 2 sampled residents (Resident #1) who exhibited wandering behavior and demonstrated a risk of elopement. Failure of the facility to assess, track/trend, and implement interventions and re-assess those interventions placed Resident #1 at risk of injury. Findings include: The Centers for Medicare and Medicaid Services (CMS) states, "Unsafe Wandering or Elopement - Wandering is random or repetitive locomotion. This movement may be goal-directed (e.g., the person appears to be searching for something such as an exit) or may be non-goal-directed or aimless. . . . Unsafe wandering may occur when the resident at risk enters an area that is physically hazardous or that contains potential safety hazards . . . Entering into another	F 323	Resident #1 is being monitored for a period of 10 days to trend wandering. An elopement risk assessment has been completed by the social worker and an individualized toileting plan will be established by the MDS nurse. The care plan and EHR will be updated. All residents who wander have the potential to be affected. The social worker will complete an elopement risk assessment on these residents and on new admissions if the information indicates they could be at risk. The care team will review these residents on a quarterly basis for potential elopement risk. Care plans and EHR will be updated to include interventions as necessary. Nursing and social service staff will be re-educated on Elopement Procedure. The Director of Nursing or designee will audit 3 charts monthly for two months, then 3 charts per quarter for the next three quarters to ensure that elopement risk has been addressed.	01/05/12

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 _____	12/01/2011

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 16 resident's room may lead to an altercation or contact with hazardous items. . . . Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. . . . Facility policies that clearly define the mechanisms and procedures for monitoring and managing residents at risk for elopement can help to minimize the risk of a resident leaving a safe area without authorization and/or appropriate supervision. In addition, the resident should have interventions in their comprehensive plan of care to address the potential for elopement. . . ." The Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), page E-19, ". . . Wandering - Impact . . . Some residents who wander are at potentially higher risk for entering an unsafe situation. Some residents who wander can cause significant disruption to other residents. Planning for Care. Care plans should consider the impact of wandering on resident safety and disruption to others. Care planning should be focused on minimizing the issues. Determine the need for environmental modifications (door alarms, door barriers, etc.) that enhance resident safety if wandering places the resident at risk. . . ." Review of facility policies and procedures occurred on November 30-December 1, 2011. A facility policy titled "Elopement," revised January 2011, stated, "PURPOSE. To assess and identify residents at risk of elopement. To clearly define the mechanisms and procedures for monitoring and managing residents at risk for elopement. . . . DEFINITION. Elopement occurs when a resident	F 323	Results of audits will be reported at the Quality Assurance Committee for further recommendations	

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 _____	12/01/2011

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 17 leaves the premises or a safe area without authorization and/or any necessary supervision to do so. PROCEDURE. . . . 4. Care plan team members should consider the following when assessing risk of elopement: a. wandering behavior. . . . Unsafe wandering and elopement can be associated with falls and related injuries. . . . 8. Residents who attempt elopement after admission: a. Residents who were assessed to not be at risk of elopement during the pre-admission process, but begin to exhibit wandering behaviors or attempt to elope during their stay in the center [facility] will be assessed and monitored in the following ways: . . . 3) Track wandering behavior/elopement attempts on the handheld [portable device used by staff for documentation]. . . . 9. Sample care plan: Problem. Potential for elopement r/t [related to] . . . wandering behavior, elopement attempts . . ." A facility policy titled "Behavior Management Committee," revised September 2010, stated, "PURPOSE. To provide information on the development and function of the Behavior Management Committee. PROCEDURE. A Behavior Management Committee is formed to analyze the root cause(s) of a resident's behavior as well as provide alternatives to staff for solutions. . . . 3) Discussion and documentation of issues for identified core residents. a) Review behavioral details; what, when, why. b) Review behavior interventions and their effectiveness. c) Develop additional or modified interventions. . . . 4) Documentation Process. . . . b) Bring care plans for updating. . . ." Record review for Resident #1 occurred on November 29-December 1, 2011. The facility	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 _____	12/01/2011

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 18	F 323		

admitted the resident on April 12, 2011 with diagnoses of Alzheimer's dementia, osteoporosis, and urinary frequency. Resident #1's admission Minimum Data Set (MDS), dated 04/18/11, and quarterly MDS, dated 10/15/11, identified Resident #1 with severe cognitive impairment.

Resident #1's "Pre-Admission Case Management Data" assessment, dated 04/12/11 (day of admission), identified no wandering or history of elopement; however, a note on the assessment form, stated, "Wandering risk at [prior facility]. Do not know how she will do in a new place."

Review of Resident #1's interdisciplinary notes identified wandering behavior present starting in July of 2011. The notes showed the following:

* 07/22/11- Resident #1 wandered into two separate resident's rooms to use the bathroom. The residents became upset and began yelling.

* 08/14/11- wandered into another resident's room to use the bathroom.

* 08/21/11- exited the east door of the building and walked to the end of the sidewalk by herself. Re-entered the building with redirection/supervision from staff. Later that evening, staff observed the resident exiting another resident's bathroom after using it.

* 08/23/11- wandered into another resident's room to use the bathroom.

* 09/04/11- wandered into a resident's room to use the bathroom.

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 _____	12/01/2011

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 19 * 09/10/11- indicated the resident needed supervision and re-direction if wandering down the wrong hallway. * 10/11/11- a nursing quarterly progress note indicated Resident #1 becomes confused and uses other residents' bathrooms when unable to find her own. The note indicated this behavior upsets other residents and indicated Resident #1 has a toileting plan in place. Review of Resident #1's current comprehensive care plan identified the following: "Alteration in behavior R/T [related to] dementia . . . wandering into other residents' rooms to toilet. . . . assess for toileting needs and toilet as needed. Monitor whereabouts throughout shift. Document all behavior incidents. . . ." The resident's toileting plan showed the following: "Alteration in bowel/urinary elimination R/T . . . dementia . . . history of urinary frequency. . . . Offer toileting upon rising, before brunch, following afternoon nap, before supper, at bedtime and Q [every] 4 HRS [hours] during NOC [night] and PRN [as needed]." Review of the facility's computerized documentation, generated from the CNAs' handheld device on 11/30/11, showed only two entries regarding Resident #1's wandering. The documentation failed to include Resident #1's exit from the building on 08/21/11, in accordance with the facility's elopement policy to track wandering behavior/elopement attempts on the handheld device used by staff. The medical record lacked evidence facility staff tracked the resident's wandering, consistently	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 _____	12/01/2011

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 20 documented the wandering behavior or re-assessed the resident's current toileting plan to determine if a more individualized toileting plan would prevent Resident #1 from using other residents' bathrooms for toileting. The record further lacked an elopement risk assessment following the incident on 08/21/11, in which Resident #1 exited the building. During an interview on 12/01/11 at 8:00 a.m., a social services staff member (#3) stated she is the head of the facility's Behavior Committee, which meets monthly. She stated she did not know of Resident #1's exit from the building on 08/21/11. This staff member stated the facility did not complete an elopement risk assessment, and Resident #1 did not currently have a wanderguard device or other interventions in place to address her exit seeking behaviors. Review of the Behavior Committee Meeting Minutes for July-October 2011 occurred on 12/01/11. The committee met on 07/20/11, 08/17/11, 09/21/11, and 10/19/11. The committee members discussed Resident #1's behaviors on 09/21/11 and added a toileting and behavior plan to her careplan. The meeting minutes lacked evidence the committee discussed Resident #1's exit from the building on 08/21/11. During an interview on the morning of 12/01/11, an administrative nurse (#2) stated she did not know of the incident of Resident #1 exiting the building on 08/21/11. She further stated the nurse who received the report from the CNA should have updated the careplan to include Resident #1's exit from the building.	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 _____	12/01/2011

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 21 During an interview on 12/01/11 at 10:30 a.m., this administrative nurse (#2) and a second administrative staff member (#1) acknowledged a lack of communication regarding Resident #1's exit from the building on 08/21/11 and stated they did not expect the CNA to document this in the handheld device, but rather, report it to the nurse. This is a contradiction to the facility's own policy regarding documentation of elopement behaviors in the handheld device and may have contributed to the lack of communication between the staff and the Behavior Committee. These staff members confirmed they could not find a toileting assessment for Resident #1 to indicate whether Resident #1's current toileting plan is appropriate or effective to address her wandering into other residents' rooms. The facility failed to consistently track Resident #1's wandering behaviors and failed to communicate pertinent information to the appropriate staff or committee. The facility's lack of appropriate assessment and re-assessment of the resident's wandering and failure to follow the facility's own written policies and procedures placed Resident #1 at risk of harm due to the potential for altercations with other residents, and increased the risk for further episodes of leaving the building unattended.	F 323		