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 _____	12/18/2013

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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 December 16, 2013 and completed on December 18, 2013 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 five (5) 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/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 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rita J. Roberg	Administrator	1-15-14

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.

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	The responsible parties for Resident #3 and Resident #16 have been contacted to verify which option they wanted when they signed the Notification of Non-Coverage. Both parities confirmed that they do not want a demand bill and have initialed and dated this choice on the non coverage form. A note will be written in the progress notes in the EMR. All residents with a Medicare A stay have the potential to be affected in this area. A list of residents with a Med. A benefit period in the past 12 months will be generated and each resident will have the Notifications of Non-Coverage reviewed to ensure that an option was checked. If the option is not checked on the non coverage form, the responsible party will be contacted to verify which option they chose and a note will be written in the progress notes of the EMR. The facility procedure for processing the "Notification of Non-Coverage" will be updated to include instructions for follow-up if an option is not checked when the form is signed. A Medicare consultant from National Campus will educate the Medicare Coordinator and the Office Manager on the procedure for ensuring that an option is checked on the "Notification of Non-Coverage" form.	01/22/14

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F 156	Continued From page 2 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of Medicare billing records, policy and procedure review, and staff interview, the facility failed to contact the resident and/or representative to determine if a demand bill should be submitted for 1 of 1 sampled resident's (Resident #3) and 1 of 1 supplemental resident's (Resident #16) medicare records reviewed. This failure has the potential to affect all Medicare beneficiaries of this facility. Findings include: The facility's policy, "Notification of Non-Coverage on Continued Stay," dated April 2013, refers to CMS (Centers for Medicare/Medicaid Services) Pub. (publication) 100-4: Chapter 30, Section 70 which states, ". . . The patient or the authorized representative must select one option. If the patient selects Option 1, the patient may receive the subject extended care items or services, for which a demand bill must be submitted to Medicare for an official determination. If the	F 156	The office manager will keep a record of all notices of non-coverage on the "Denial/Demand Bill Log". The Medicare A coordinator will designate a third party to audit all "Notification of Non-Coverage" forms and the "Denial/Demand Bill Log" weekly to ensure if the demand bill option was checked on the form and recorded on the log. The audit will be completed weekly for four weeks, then monthly for two months. The results of the audits will be reviewed by the QA committee for recommendations and/or follow-up.	

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F 156	Continued From page 3 patient selects Option 2, the patient has elected not to receive the subject extended care items or services." Review of the facility's Medicare billing records occurred on 12/17/13. The records identified Resident #3 and Resident #16's Medicare coverage ended on the following dates: Resident #3: 09/30/13 Resident #16: 06/16/13 and 08/30/13 The above residents received a "SNF [Skilled Nursing Facility] Determination on Continued Stay" form (a denial notice - including the option to request a demand bill). The form included the following two options: *"I do want my bill submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted. You are not required to pay for services which could be covered by Medicare until a Medicare decision has been made. . . ." *"I do not want my bill submitted to the intermediary for a Medicare decision. I understand that I do not have Medicare appeal rights if no bill is submitted." Resident #3 and #16's denial notices lacked an identified response to these two options. The facility failed to contact the resident and/or their representative to determine if a demand bill should be submitted. During an interview on the morning of 12/17/13, an office manager (#1) stated facility staff do not consistently contact the resident or representative if they did not indicate whether to submit a demand bill. This staff member confirmed he had	F 156		

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F 156	Continued From page 4 not submitted a demand bill for these residents.	F 156		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, review of facility procedures, and staff interview, the facility failed to ensure staff followed professional standards of practice regarding medication administration for 6 of 10 residents (Resident #5, #7, #12, #13, #14, and #15) observed during medication administration. Failure to ensure staff administered medications at the right time may affect the efficacy of the medications. Findings include: Kozier and Erb's, Fundamentals of Nursing, Concepts, Process, and Practice 9th ed., Pearson, 2012, pg 864, stated: "Ten 'Rights' of Medication Administration . . . Right Time: Give the medication at the right time frequency and at the time ordered according to agency policy. . . ." The facility provided a document "Medication Pass Times" during the entrance conference on the afternoon of 12/16/13. This undated document identified medication passes occurred at the following times: "Morning pass: 7:15 am to 11:00 am Noon Meds [medications]: 11:00 am - 12:00 pm 2:00 pm Pass	F 281	Medication administration times for residents #5, #7, #12, #13, #14 and #15 have been reviewed. Medication administration times have been adjusted as necessary to comply with pharmacy recommendations and professional standards. All residents that receive medication have the potential to be effected in this area. All residents' drug regimen med pass times will be reviewed for appropriate administration times based on the different medication classifications and if the administration times of each medication is appropriate. Each residents' medications will be reviewed with input from the primary care physician, pharmacy consultant, professional standards, and allow for resident choice. The 2013 Nursing Drug Handbook will be used as a guide. Nurses were educated on the procedure titled, "Medication Administration" from the on line EMR Nursing Services Manual with a focus on the importance of	01/22/14

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F 281	Continued From page 5 Supper Meds: 4:30 pm to 6:00 pm HS [Hour of Sleep] Pass: 6:30 pm - ?" Review of the facility procedure "Administration of Medication" occurred on 12/18/13. The procedure, revised November 2013, stated, "Purpose: To promote health and prevent disease . . . Procedure: . . .4. Using the specific center's medication system, administer medications to the resident according to the 'Six Rights:' . . . Right time . . . 7. Administer medications at least within 60 minutes on each side of ordered time, except for 'stat' medications which must be given immediately or other time-sensitive medications. . . ." Observations of medication administration identified the following: * 12/16/13 at 4:48 p.m.: A licensed nurse (#4) administered a multivitamin and senna plus (a stool softener) to Resident #7. The medication administration record (MAR) identified the administration times as "PM [afternoon] pass." * 12/16/13 at 5:00 p.m.: The nurse (#4) administered metformin (for diabetes), Namenda (for dementia), and omeprazole (to reduce stomach acid) to Resident #12. The MAR identified the medication administration times as "PM pass." * 12/17/13 at 8:12 a.m.: A licensed nurse (#5) administered Synthroid (thyroid hormone replacement) and psyllium (bowel medication) to Resident #13. The MAR identified the administration times as "AM [morning] pass." * 12/17/13 at 8:16 a.m.: The nurse (#5) administered hydrochlorothiazide (HCTZ) (a diuretic) and diltiazem (blood pressure medication) to Resident #5. The MAR identified the medication administration times as "AM	F 281	giving medications at times that maximize their effectiveness and allow for resident choice. Nurses will receive additional training on how to full utilize the Electronic medication administration record (E-MAR), how to review the times of previous doses given, and how to input physician orders. The DON or designee will be responsible to complete an audit the medication pass times. The audit will be completed on 3 to 5 random residents for one med pass for three days; then one med pass for 3 to 5 residents weekly for four weeks; then one med pass for 3 to 5 residents quarterly for two quarters to ensure that medications are being given according to pharmacy recommendations and professional standards. Results of the audits will be given to the QA committee for review and follow-up.	

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F 281	Continued From page 6	F 281		

pass."
* 12/17/13 at 8:30 a.m.: The nurse (#5) administered aspirin, vitamin D3, Coreg (blood pressure medication), Lamictal (seizure medication), Lasix (a diuretic), lisinopril (blood pressure medication), and Prozac (for depression) to Resident #14. The MAR identified the medication administration times as "AM pass."
* 12/17/13 at 10:50 a.m.: The nurse (#5) administered glipizide (for diabetes), HCTZ, Januvia (for diabetes), omeprazole, Zoloft (for depression), and Vitamin D to Resident #15. The MAR identified the medication administration times as "AM pass."

An interview with a licensed nurse (#5) occurred on 12/17/13 at 2:05 p.m. The nurse stated the facility set the medication administration times as AM and PM to allow the nurses time to complete the medication pass and to allow residents to "sleep in" if they so desire. When asked how staff determine when the resident received the last dose of a medication given more than once daily, the nurse (#5) stated the facility's computerized MAR can not bring up that information for nurses to view. The nurse provided an undated document kept on the medication cart which identified the following administration times "HS 2100 [9:00 p.m.] - 2200 [10:00 p.m.]; PM 1630 [4:30 p.m.] - 1900 [7:00 p.m.]; AM 7:15 - 1100 [11:00 a.m.]" The times on this document did not match the times provided at the entrance conference. Both schedules defined a 3 hour and 45 minute time frame for the morning medication pass.

An interview with an administrative nurse (#2) occurred on 12/17/13 at 3:55 p.m. The nurse

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F 281	Continued From page 7 agreed proper spacing of medications could be difficult when the nurse cannot view the time staff administered the previous dose and the MAR does not define a specific time for administration. Review of the electronic medication administration records occurred on 12/18/13 at 8:50 a.m. with a health information management staff member (#6). The review identified staff administered Resident #15's AM medications (including those for diabetes) at 9:11 a.m. on 12/12, 8:46 a.m. on 12/13, 8:36 a.m. on 12/14, 7:46 a.m. on 12/15, 9:42 a.m. on 12/16, and 10:53 a.m. on 12/17. The inconsistent administration times could result in poor control of the resident's blood glucose levels. Refer to F332.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility protocol, policy and procedure, and staff interview, the facility failed to assess and implement interventions to promote regular bowel elimination for 2 of 2 sampled residents (Resident #4 and #6) with a diagnosis of constipation.	F 309		

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F 309	Continued From page 8 Failure to implement appropriate and timely interventions may have resulted in unrelieved constipation. Findings include: Review of the facility's "Bowel Regime" stated, "Check BM [bowel movement] book daily, If no BM on second day, offer MOM [Milk of Magnesia] Miralax, Senokot [laxatives] etc. (What is ordered per resident.), Make out BM list et [and] place in front of MARS [medication administration records], Next day, if no results, repeat MOM, Miralax, Senokot et etc., and make out BM list et note if no results. Supp [suppository] needed in am for night nurse." Review of the facility's policy titled "Bowel Management Program," dated March 2009, stated, ". . . Purpose: To promote normal bowel function with a proactive approach by adding fiber to food/fluids. Procedure: 1. Nursing/dietary to identify residents who may benefit from a bowel management program. 2. Food/fluid interventions maybe established by the director of dietary services (DDS). . . . ." - Review of Resident #6's medical record occurred on December 16-18, 2013. Diagnoses included constipation and dementia. Daily medications included an iron supplement (may cause constipation), initiated on 09/12/13, and Senokot S (a laxative/stool softer), initiated on 10/14/13. Resident #6's current care plan stated, "The resident has constipation R/T [related to] decreased mobility and medication E/B [effected by] need for medication . . . goal the resident will	F 309	The bowel regimes, physician orders, dietary interventions, and BM documentation for residents #4 and #6 were reviewed. Dietary interventions were added to the plan of care for resident #6, a physician order for MOM was obtained and the care plan was updated. Resident #4's physician orders for bowel care were reviewed and the plan of care addresses constipation. Nurses and CNA's were instructed on the facility's bowel management plan of care and to document according to facility procedure. All residents with a diagnosis of constipation have the potential to be affected in this area if the bowel regime is not properly carried out. The "No BM Report" will be run daily and the bowel care regime will be followed. Nursing will notify dietary if a resident is given a new medication that could cause significant constipation. Plan of care will be revised as necessary. The DON provided training for the CNA's on January 2, 2014 to re-educate them on the importance of charting BM's. On January 7, 2014, the DON provide training for the nurses to re-educate them on the bowel regime procedure, the importance of running the BM report	01/22/14

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F 309	Continued From page 9 pass soft, formed stool at the preferred frequency q [every] 1-2 days through the review date . . . plan/approach . . . Observe/monitor/document/report to health care provider PRN [as needed] s/s [signs and symptoms] of complications related to constipation: swollen abdomen, small loose stools, fecal smearing, bowel sounds, abdomen tenderness, guarding, rigidity." The care plan lacked dietary interventions to decrease complications related to constipation. Review of the dietary manager's most recent dietary progress note/assessment, dated 11/22/13, and review of a list of residents who receive fiber enhanced drinks or prune juice failed to identify dietary interventions for Resident #6 or the problem of constipation. Review of Resident #6's BM record from June to December 2013 identified the following days the resident did not have a BM and facility staff failed to provide an as needed (PRN) laxative: *June 22-27 (6 days) *July 2-5 (4 days) *August 23-26 (4 days) *September 4-7 (4 days) *October 26-30 (5 days) *November 11-14 (4 days) *December 13-16 (4 days) During an interview on 12/18/13 at 10:45 a.m., an administrative nursing staff member (#2) confirmed nursing interventions for constipation should have been implemented per bowel protocol for Resident #6. During an interview on 12/18/13 at 11:00 a.m., an administrative dietary staff member (#3)	F 309	daily and following up on residents that have not had a bowel movement in 2 days. The DON re-educated the dietary manager on the need for dietary interventions for constipation. The DON or designee will run the BM report daily for three days to ensure that all residents are having regular BM's and follow-up as necessary. The BM audit will be completed weekly for 4 weeks then monthly for two months. Results of the audits will be given to the QA committee for review and follow-up.	

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F 309	Continued From page 10 confirmed she should have added dietary interventions for constipation for Resident #6. - Review of Resident #4's medical record occurred on December 16-18, 2013. Diagnoses included constipation. Review of the resident's current physician's orders included a dulcolax suppository every 24 hours PRN; milk of magnesia with prune juice daily; Senokot S one tablet daily; and oxybutynin (medication for overactive bladder) 5 mg two times a day (side effects included constipation). Resident #4's current care plan stated, "Alteration in bowel and bladder elimination r/t decreased mobility and need for oxybutynin, recurring UTI [urinary tract infection]. E/B frequently incontinent of bladder and at times of bowel constipation . . . will have formed BM no less then Q 3 days . . . plan/approach . . . monitor bowel function daily. Notify M.D. PRN of peristent [sic] diarrhea or constipation. Fiber basics juice daily." Review of Resident #4's BM record for the month of October 2013 identified a 7 day period (October 16-22) without a BM. The medication administration record identified a dulcolax suppository given on October 21(day 6). The record indicated the resident did not have a BM until 3 days after the suppository and no other interventions had been attempted. During an interview on the morning of 12/18/13, an administrative nursing staff member (#2) reported the staff should have given a suppository on the morning of the fourth day.	F 309		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		

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F 332	Continued From page 11 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional references, facility procedures, and staff interview, the facility failed to ensure a medication error rate of less than 5% during 3 of 3 observations of medication administration (on the afternoon of 12/16/13 and morning of 12/17/13). Failure to ensure staff administered medications at the right time resulted in a medication error rate of 13%. Findings include: Kozier and Erb's, Fundamentals of Nursing, Concepts, Process, and Practice 9th ed., Pearson, 2012, pg 864, stated: "Ten 'Rights' of Medication Administration . . . Right Time: Give the medication at the right time frequency and at the time ordered according to agency policy. . . ." Review of the facility procedure "Administration of Medication" occurred on 12/18/13. The procedure, revised November 2013, stated, "Purpose: To promote health and prevent disease . . . Procedure: . . .4. Using the specific center's medication system, administer medications to the resident according to the 'Six Rights:' . . . Right time . . . 7. Administer medications at least within 60 minutes on each side of ordered time, except for 'stat' medications which must be given immediately or other time-sensitive medications. . . ."	F 332	(See also F 281) Medication Administration times for residents #12, #13 and #15 have been adjusted to ensure that omeprazole, synthroid and glipizide are given before meals. All residents that are given medications that must be given before meals (such as omeprazole, synthroid, glipizide, etc.) have the potential to be affected in this area if medications are not given at appropriate times. All resident medication administration times for these types of medications will be reviewed and revised as necessary to maintain professional standards. The 2013 Nursing Drug Handbook will be used as a guide. Nurses were educated January 7, 2014 on the procedure titled, "Medication Administration" from the EMR on line Nursing Services Manual and on the importance of giving medications at times that maximize their effectiveness. The DON or designee will audit the times medications are given that must be administrated before meals. The audit will be completed for two residents, on one medication pass, for three days; then two residents, on one medication pass, weekly for four weeks; then two	01/22/14

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 _____	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 332	Continued From page 12 Information quoted regarding the following medications was obtained from the Nursing 2013 Drug Handbook, Lippincott, Williams, and Wilkin, Philadelphia. Observations of medication administration identified the following: * 12/16/13 at 5:00 p.m.: The nurse (#4) administered omeprazole (to reduce stomach acid) 20 milligrams (mg) to Resident #12 while the resident ate his meal. The Medication Administration Record (MAR) identified the medication administration time as "PM pass." The Nursing 2013 Drug Handbook, page 1011, stated (regarding omeprazole), "Give drug at least 1 hour before meals." * 12/17/13 at 8:12 a.m.: A licensed nurse (#5) administered Synthroid (thyroid hormone replacement) 50 micrograms to Resident #13 while the resident ate breakfast. The MAR identified the administration time as "AM pass." The Nursing 2013 Drug Handbook, page 817, stated (regarding Synthroid), "Give drug at the same time each day on an empty stomach, preferably 1/2 to 1 hour before breakfast." * 12/17/13 at 10:50 a.m.: The nurse (#5) administered glipizide (for diabetes) 5 mg 1/2 tablet and omeprazole 20 mg to Resident #15 while the resident ate brunch. The MAR identified the medication administration time as "AM pass." The Nursing 2013 Drug Handbook, page 662, stated (regarding glipizide), "Give immediate release tablet about 30 minutes before meals." An interview with a licensed nurse (#5) occurred on 12/17/13 at 2:05 p.m. The nurse stated the	F 332	residents, on one medication pass monthly for two months to ensure the medications are given before meals. Results of the audits will be given to the QA committee for review and follow-up.	

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F 332	Continued From page 13 facility set the medication administration times as AM and PM to allow the nurses time to complete the medication pass and to allow residents to "sleep in" if they so desire. An interview with an administrative nurse (#2) occurred on 12/17/13 at 3:55 p.m. The nurse confirmed the facility MARs did not define a specific time for administration of all medications. Failure to define a specific time to administer time-sensitive medications (as per facility policy) resulted in medication errors and may have resulted in decreased efficacy of the medications.	F 332		