STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOHALL	602 E MAIN ST MOHALL, ND 58761

(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 and complaint investigation started on April 14, 2014 and completed on April 16, 2014 the sample included three (3) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r). This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, review of facility policy and procedures, and staff interview, the facility failed to provide sufficient preparation to a resident/responsible party to ensure safe and orderly discharge from the facility for 1 of 1 sampled resident (Resident #13) discharged to a hospital.	F 204	F 204 1. Resident #13 was discharged on 2/4/14. 2. All residents are at risk for possibility of transfer/discharge. 3. Going forward the center will follow policy/procedure and federal regulation regarding resident transfer/discharge. The appropriate staff were re-educated on 5/21/14 regarding transfer/discharge procedures. These staff members included the following: Robert S. Administrator, Beth S. DON, Deanna O. ADON, Sandra B. Dir. of Social Services, and Darice H. MDS Coordinator. 4. All involuntary discharges will be audited should the situation occur in the future, and results will be reported to the QA committee for further recommendations. 5. Date in compliance	5/21/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert S Heckler	Administrator	5/22/14

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 204	Continued From page 1 Findings include: Information provided by the complainant indicated the facility transferred Resident #13 to a local hospital for medical care and refused to re-admit her due to non-payment, "dumping" her into the hospital versus discharging her to an appropriate residence. Review of facility policy titled "Discharge/Transfer" occurred on 04/16/14. This policy, dated September 2012, stated, "A center must provide sufficient preparation and orientation to residents to ensure safe and orderly . . . discharge from the center. . . . The center should actively involve, to the extent possible, the resident and the resident's family in selecting the new residence. Documentation of this preparation will be made in the medical record. . . ." The interdisciplinary progress notes identified the following: * 12/27/12, "[Son] was given Notice of Transfer or Discharge due to non payment. [Son] plans on picking [Resident #13] up on Jan 9, 2013. [Son] was given a thirty day notice. [The ombudsman] stated . . . [the facility] needs to assist with discharge planning with [son]. . . ." * 01/03/13, "[Son] attended care plans today. . . . [Resident #13] will be discharged into son's care. Will be living with son and wife. Discharge plans documented. . . ." Documentation from an administrative hearing, dated 03/05/13, identified, ". . . that [Resident #13] has failed to pay and failed to make arrangements to pay nursing facility charges . . . and thus [the facility] may discharge [Resident #13] . . . to [son's address]. . . ."	F 204		

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F 204	Continued From page 2 During interview on 04/16/14, an administrative staff member (#6) stated, "Her son was supposed to get her, he refused . . . He said he's disabled and can't take care of her." The administrative staff member (#6) further stated that Resident #13's family refused to pay for the care she continued to received at [the facility]. An interdisciplinary progress note, dated 02/02/14, identified, "T/C [telephone call] to [son] and notified of decreased oral intake and possible dehydration, going to take to [local hospital] for evaluation. . . ." A notice of bed hold, dated 02/02/14, identified, ". . . I do . . . request that a bed be held during this leave of absence. . . ." A handwritten notation further identified, "T.C. to [son] - yes - hold bed. . . ." An interdisciplinary progress note, dated 02/04/14, identified, "The facility received a phone call from [local hospital] discharge planner . . . regarding [Resident #13's] plan for discharge from the hospital. [Resident #13] is expected to be medically stable to return to the facility on 02/05/14. The administrator called and spoke with [discharge planner] to inform her of the facility decision to not readmit [Resident #13] back to this facility due to non payment. . . . [Facility attorney] prepared letters for both [son and daughter] informing them of the discharge notice due to non payment. . . ." Resident #13's medical record lacked evidence the facility provided the resident/legal representative a post discharge plan of care addressing her limitations and assisting her in her	F 204		

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F 204	Continued From page 3 new residence.	F 204		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	F 225 1. Resident #1 had a report sent to ND State Health Department on 4/29/14 for injury of unknown origin (bruise) and potential neglect (fall from Bath chair). Results of the investigations showed the alleged violations were unsubstantiated and reports were sent respectively 5/2/14 and 5/5/14. 2. All residents with a fall/incident or injuries of unknown origin have the potential to be affected. 3. A) Charge nurses and DON were re-educated 4/23/14 on the definitions of an injury of unknown origin and the definition of neglect. The education included that if the injury is suspicious and/or meets the definitions of abuse or neglect, the facility is required to notify the ND State Health Dept. immediately (within 24 hrs).	Reports Sent to our office filed HR

5/22/14

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F 225	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure allegations of potential abuse and neglect (including injuries of unknown origin) were thoroughly investigated and reported for 1 of 1 sampled resident (Resident #1) with an injury of unknown origin and a fall from the bath chair. Failure to investigate and report these incidents places all residents at risk for mistreatment and neglect. Findings include: Review of the facility policy titled "Abuse and Neglect" occurred on 04/16/14. This policy, revised September 2013, stated, ". . . The charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required, and complete an initial investigation. If this is an injury of unknown origin, he or she also will attempt to determine the cause of the injury. . . . Alleged or suspected violations involving any mistreatment . . . including injuries of unknown origin will be reported immediately to the center administrater and to other officials in accordance with state law, including the state survey and certification agency. . . . The investigation team will determine whether further investigation is needed. . . . The investigation may include interviewing staff, residents, or other witnesses to the incident. . . ." Review of Resident #1's medical record occurred	F 225	B) A laminated card with the fax number for the ND State Health Dept. was developed and put in Check list box at each nurse's station. C) Nursing assistants have been re-educated during a series of mini meetings the weeks of 4/28/14 through 5/9/14 to report injuries of unknown origin/bruises to the Charge nurse, and that 'injuries of unknown origin/bruises or failure to provide goods and services (neglect)' must be reported to the State Health Dept. immediately (within 24 hrs). 4. The DON, or designee, will be responsible to audit/monitor all resident incidents of falls or injury of unknown origin/bruise to ensure the Charge Nurses have notified the State Health Dept. within 24 hrs if the definition of injuries of unknown origin or neglect has been met.	

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F 225	Continued From page 5 on all days of survey. Diagnoses included senile dementia, rheumatoid arthritis, and osteoarthritis. An Incident Report, dated 10/31/13 at 1:50 p.m., identified the following: ". . . Alleged Nature of Incident . . . leaned forward off bath chair, landed on [right] side body [sic] . . . Res [resident] stated 'Ouch' when landed on the floor. . . . Type of Alleged Injury: . . . Bruise . . . Size: golf ball . . . Ice placed on [right] side head [sic] for 20 mins. [minutes] Medicated [with] PRN [as needed] Ibuprofen given. . . ." The facility's investigation of the above incident identified the following: ". . . CNA [certified nursing assistant] was lowering bath chair [with] res. sitting in it. Res leaned forward et [and] landed on floor hitting [right] side of head. Strap not around [Resident #1]. . . . CNA stated Resident was sitting so well [and] she was lowering the bath chair. She didn't have the strap on cause she was sitting so well. DON [director of nursing] counseled CNA to use strap all the time. . . ." During an interview on 04/16/14 at 11:32 a.m., a supervisory nurse (#1) stated the facility educates all staff to use the seat belt on the bath chair with all residents. Failure to identify the above incident as possible neglect and report the incident to the state survey and certification agency placed other residents at risk for mistreatment and injuries related to the use of the bath chair. Resident #1's medical record also included an incident report, dated 03/24/14 at 8:42 p.m., which identified the following: ". . . Incident Description . . . Family noted bruising to left	F 225	Each audit report will be filed x 4 weeks, then monthly x 2, quarterly through one year, and prn. The DON, or designee, will submit a report of the monitoring to the QA Committee for review and additional audit recommendations. 5. Date in compliance	5/16/14

(22) 5/22/14

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F 225	Continued From page 6 forearm on 03/17/2014. . . ." The incident report (completed seven days after the initial report of the bruise) lacked investigation as to possible causes for the bruise. A Progress Note, completed by the mental health practitioner on 03/18/14, stated, ". . . bruise to [left] forearm . . . from thrashing and hitting out at staff the bruise looks like she could have hit the arm of her chair - or even bed rail . . ." Although the mental health practitioner addressed the bruise on 03/18/14, the facility failed to identify the bruise as an injury of unknown origin and begin an initial investigation (by the charge nurse or licensed nurse as per facility policy) when the family reported the bruise on 03/17/14. This failure places all residents at risk for mistreatment, neglect, and abuse. During an interview on 04/16/14 at 10:08 a.m., a supervisory nurse (#7) agreed the initial investigation of the bruise should be documented by staff.	F 225	F 244 1. As of 4/22/14 we implemented a new process of serving residents during meal times. Cooks now come out to the dining tables after the meals have been served, and communicate with residents regarding their meal satisfaction and any possible need for an alternative food choice. Dietary Assistants are now checking in with residents during their meals to offer more assistance or additional food and drink. 2. All residents have the potential to be affected. 3. A) All Dietary Staff were educated on 4/22/14 regarding the new dining process as well as how to complete the new tracking tool.	
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on review of monthly resident council	F 244		

5/22/14

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F 244	Continued From page 7 meeting minutes, group resident interview, staff interview, and policy and procedure review, the facility failed to act upon grievances expressed by 8 of 11 residents (A, B, C, D, E, F, G & H) during group interview; specifically concerns about the service during mealtimes. Failure to act upon the grievances of the residents resulted in residents continuing to be dissatisfied and continuing to submit verbal grievances during resident council meetings. Findings include: Review of the facility's procedure titled "Grievances, Complaints or Concerns" occurred on 04/16/14. This policy, dated February 2013, stated, ". . . PROCEDURE . . . 3. If the problem can be resolved immediately, the staff member will thank the individual for the information and proceed to take action regarding that problem . . . 8. An investigation must be completed for all grievances . . . 7. The social services director then will report the findings to the individuals filing the concern and to the center administrator. . . ." Review of the facility's Resident Council Minutes from May 2013 - April 2014 occurred on the afternoon of 04/14/14. The Resident Council Minutes, for six of the twelve months reviewed, identified, "Dietary . . . wish the employees would ask if anything else is needed after a meal is served. Some would like more assistance with cutting, getting coffee, extra utensils, getting condiments, etc . . . They [residents] stated some employees are very good at asking but many never ask . . . ." The most current Resident Council Minutes, dated 04/08/14, stated, ". . . They [residents] still feel that the tables do not receive follow up service after the meal is brought	F 244	B) Effective 5/13/14, Activities Staff will be responsible for completing a GSS #213 Suggestion or Concern form should a resident or group of residents express any concerns or possible suggestions during the monthly Resident Council meeting. All residents residing in the facility have access to fill out or request help filling out the GSS #213 at any time. Activities Staff will forward the GSS #213 on to the Administrator who will review it, determine whether further action is needed, and assign the appropriate parties to further investigate and come to a resolution as needed. 4. A new tracking tool was implemented as of 4/22/14 in which both the Cook and Dietary Assistant initial after completing the new dining process at each meal. In addition to the tracking tool,	

(A) 5/22/14

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F 244	Continued From page 8 to them. Few staff members are asking it [sic] they need anything additional or offer to warm up drinks or bring needed items such as more napkins, crackers, condiments, etc. . . ." During the survey's group interview, on 04/14/14 at 3:30 p.m., eight of the eleven residents present (Resident A, B, C, D, E, F, G & H) agreed staff were still not making sure to ask if the residents needed anything additional during the three daily meals serviced. Those same residents (identified by the facility as interviewable) stated this unresolved concern had been repeated at previous council meetings. During an interview on 04/15/13 at 5:00 p.m., a dietary supervisor (#5) stated she was aware of the meal service concern. Staff have been reminded to follow-up with residents after the meal is served for any additional requests. During an interview on 04/16/14 at 10:45 a.m., an administrative staff member (#4) stated awareness of the dining service concern and verfied no Quality Improvement had been implemented.	F 244	resident's will be asked at each monthly Resident Council Meeting if they feel they are receiving good dining room service. Their responses will be recorded in the minutes and discussed at the Quality Assurance meeting. The Dietary Manager, or designee, will conduct audits by interviewing random residents from various tables at each of the mealtimes regarding their dining satisfaction weekly x 2, monthly x 3, and quarterly through a year. The Dietary Manager, or designee, will submit a report to the QA committee at scheduled meetings for additional recommendations.	
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:	F 250	5. Date in compliance	5/22/14

5/22/14

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F 250	Continued From page 9 Based on record review, and staff interview, the facility failed to provide medically-related social services for 1 of 1 sampled resident (Resident #7) who verbalized feelings of anxiety and threatening to kill herself. Failure to address the psychosocial needs of Resident #7 and develop and implement interventions related to these needs may be detrimental to the resident's psychological and mental well-being and may negatively affect her overall level of functioning. Findings included: Review of Resident #7's medical record occurred on all days of survey. Diagnoses included obsessive-compulsive disorder, moderate intellectual disabilities, and anxiety. A quarterly Minimum Data Set (MDS), dated 01/30/2014, identified Resident #7 with moderately impaired cognition, and physical, verbal and inappropriate behaviors occurred one to three days during the assessment period. Review of Resident #7's progress notes state the following: * 12/15/2013 "staff reported [resident's name] yelling loudly, 'help,' repetitively 1 time this shift staff attempted to assist, [resident's name] cont [continued] increased anxious, Stated, I want to 'kill myself' staff cont to 1-1 interact with. . . [resident's name] told staff why she said that was because she couldn't get her [audio tape] to work. . . ." * 02/01/2014 ". . . PRN [as needed] given for increased anxiety . . . .'I'm so nervous, I could kill myself' But is sitting still in her chair & [and] looking around the dining room. . . " Review of Resident #7's current care plan failed	F 250	F 250 1. Resident #7 has been assessed by the Director of Social Services (DSS), and follow-up documentation was completed regarding verbalization of suicidal thoughts on 5/6/14. 2. All residents that verbalize suicidal thoughts, or trigger on the MDS D0200.I interview question, have the potential to be affected. 3. A) Charge Nurses were educated 4/23/14 to follow up and report to DSS any resident verbalizing suicidal thoughts to ensure that the residents receive the services they need for their health and safety. Nursing Assistants were educated at mini meetings during the weeks of 4/28/14 through 5/5/14 to report any residents who verbalize suicidal thoughts. B) DSS was educated by consultant Frankie Wolhart, LSW on 4/28/14.	

RD 5/22/14

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F 250	Continued From page 10 to identify the resident's statements of self harm and a plan for interventions. Review of a mental health progress note, dated 03/18/14, failed to address statements of self harm made by Resident #7. During an interview on the morning of 04/16/14, a social services staff member (#5) stated, she was not aware Resident #7 had threatened to kill herself.	F 250	C) Resident #7 careplan was updated by DSS on 4/28/14 and 5/12/14. D) DSS reviewed GSS policy and procedure regarding Medically Related Social Services on 5/12/14.	
F 278 SS=D	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.	F 278	4. An audit tool will be developed to monitor if Social Services/Nursing provide interventions and document follow-up regarding suicidal thoughts. The DSS, or designee, will audit weekly x 1 month, then monthly x 2 months, and quarterly through one year. The DSS, or designee, will submit a report to the QA committee at scheduled meetings for additional recommendations. 5. Date in compliance	5/16/14

5/22/14

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(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 278	Continued From page 11 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 5 sampled residents (Resident #1) coded for behaviors. Failure to ensure the accuracy of the MDS may negatively impact the resident's plan of care. Findings include: The Long-Term Care Facility RAI User's Manual, October 2013, page E-1, stated, ". . . Section E: Behavior . . . The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members, or the care environment. . . ." Page E-5 stated, ". . . Steps for Assessment . . . Review the medical record for the 7-day look-back period. . . . Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period . . . Observe the resident in a variety of situations during the 7-day look-back period. . . ." Review of Resident #1's medical record occurred on all days of survey. The resident's current MDS, dated 04/04/14, identified daily physical behaviors, verbal behaviors on 1-3 days during	F 278	F 278 1. Resident #1's MDS dated 4/4/2014 was modified by DSS in section E 200A on 4/17/2014. Section E 200C was modified by the MDS Coordinator on 5/20/2014. Both modifications were done to match the behavior documentation for Resident #1. 2. All residents having behaviors have the potential to be affected. 3. When a behavior occurs, staff will document the behavior in POC or in the Progress Notes in PCC. A) Charge nurses were educated regarding the behavioral documentation process on 4/22/14. B) CNA's were re-educated on how to use POC to chart behaviors the weeks 4/28/14 through 5/9/14.	

5/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	04/16/2014

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F 278	Continued From page 12 the 7-day look back period, and daily rejection of care. Nurses' notes as well as certified nursing assistant (CNA) documentation of behaviors for the 7-day look back period identified one physical behavior of hitting which occurred on 04/03/14. The record lacked evidence of physical behaviors and rejection of care occurring daily, as well as any verbal behaviors. A social services progress note, dated 04/09/14 at 11:56 a.m. (five days after the assessment reference date [ARD]), stated, ". . . talked with CNA's to see if [Resident #1] was still being aggressive with cares. The answer was 'Yes, every day, several times a day - hitting, kicking, pushing, and some yelling. . . ." During an interview on the afternoon of 04/16/14, a social services staff member (#2) stated CNAs or nurses are expected to document each time behaviors occur, and she should have documented her interviews regarding the behaviors during the look-back period.	F 278	C) DSS was educated by consultant Frankie Wolhart, LSW on 4/28/14 regarding coding the MDS according to the behavior documentation that is in PCC. D) DSS reviewed the most recent MDS for all residents with behaviors for accuracy of coding MDS Section E. The review was completed 5/21/2014. Corrections to the MDS were completed on 5/21/2014 by the MDS Coordinator. 4. DSS will interview staff regarding behaviors that occurred, and then compare the interview responses with documented behavior in PCC. The audit will be completed weekly x 4 weeks, monthly x 3 months, and once quarterly through the year, using 2 residents per audit. The DSS will submit audit reports to the QA committee at scheduled meetings for additional recommendations.	
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	F 323	5. Date in compliance	5/21/14

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F 323	Continued From page 13 by: Based on record review, review of manufacturer's recommendations, and staff interview, the facilty failed to provide supervision and assistive devices necessary to prevent accidents for 1 of 1 sampled resident (Resident #1) with a fall from the bath chair. Failure to ensure Resident #1's safety during a transfer in the bath chair resulted in a fall with a head injury. Findings include: Review of the "Penner" Patient Transfer/Lift System (bath chair) manufacturer's instructions occurred on 04/16/14. The instructions stated on page 9-13, ". . . Warning . . . Failure to secure the resident properly with the seat belt could result in injury to the resident or operator . . . Penner Transfer Procedure . . . With Resident properly secured with belting, raise the Transfer to the appropriate height to clear the entry of the tub. . . . Once the transfer is in the correct position, lock the casters, ensure the residents hands, arms, and legs are all clear. Close the access door of the tub. . . . Position the Penner Transfer for a transfer back to bed or to another chair. Lock the casters. . . . Release the seat belts from around the resident and transfer the resident using proper nursing techniques and assistance if required. . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included senile dementia, rheumatoid arthritis, and osteoarthritis. An Incident Report, dated 10/31/13 at 1:50 p.m., identified the following: ". . . Alleged Nature of Incident . . . leaned forward off bath chair, landed on [right] side body [sic] . . . Res [resident] stated	F 323	F 323 1. Resident #1 is currently being bathed in the bath chair with the safety belt on. 2. All residents who use a bath chair when bathing have the potential to be affected. 3. A) CNA's received education the weeks of 4/28/14 through 5/9/14 in the proper application and use of the bath chair safety belt. B) A new procedure for the use of the bath safety belt was developed on 4/28/14. 4. An audit tool will be developed to monitor staff bathing residents using the bath chair and belt correctly. The DON, or designee, will complete the audit weekly x 2, then monthly x 2, and quarterly through the year.	

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F 323	Continued From page 14 'Ouch' when landed on the floor. . . . Type of Alleged Injury: . . . Bruise . . . Size: golf ball . . . Ice placed on [right] side head [sic] for 20 mins. [minutes] Medicated [with] PRN [as needed] Ibuprofen given. . . ." The facility's investigation of the above incident identified the following: ". . . CNA [certified nursing assistant] was lowering bath chair [with] res. sitting in it. Res leaned forward et [and] landed on floor hitting [right] side of head. Strap not around [Resident #1]. . . . CNA stated Resident was sitting so well [and] she was lowering the bath chair. She didn't have the strap on cause she was sitting so well. DON [director of nursing] counseled CNA to use strap all the time. . . ." During an interview on 04/16/14 at 11:32 a.m., a supervisory nurse (#1) stated the facility educates all staff to use the seat belt on the bath chair with all residents.	F 323	The DON, or designee, will submit reports to the QA committee at scheduled meetings for additional recommendations. 5. Date in compliance	5/16/14
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329	F 329 1. Resident #1's behavior symptom careplan was updated 4/17/14 with the following items: 1) Attempt non-pharmacological interventions such as letting her hold her dog, play polka music, and offer a snack.	

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F 329	Continued From page 15 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to ensure a regimen free from unnecessary medications for 1 of 6 sampled residents (Resident #1) identified with behaviors. Failure to ensure adequate indications for the use and increase of Depakote (an anticonvulsant) may result in Resident #1 receiving an unnecessary medication and suffering adverse consequences related to its use. Findings include: The "Nursing 2013 Drug Handbook," 33rd edition, Lippincott, Williams & Wilkins, Pennsylvania, page 1379-1380, stated, ". . . divalproex sodium [Depakote Sprinkle] . . . INDICATIONS . . . simple and complex absence seizures, mixed seizure types . . . complex partial seizures . . . Mania . . . To prevent migraine headache . . . ADVERSE REACTIONS . . . insomnia . . . somnolence . . . abnormal thinking . . . amnesia . . . depression . . . emotional upset . . ." Review of Resident #1's medical record occurred	F 329	2) Minimize potential for resident's hitting, pinching, and/or kicking by offering tasks which divert attention such as letting her hold her puppy during cares. Resident #1 will be re-assessed by Vickie Weathers, CNS on 5/13/14. 2. All residents receiving medications for mood/behaviors have the potential to be affected. 3. A) Charge nurses were re-educated 4/22/14 to document all behaviors witnessed or reported in the PCC Progress Notes or POC. B) CNA's were re-educated on how to use POC to chart all behaviors, and the importance of charting all behaviors during the weeks of 4/28/14 through 5/9/14. C) Prior to Behavior meetings, DSS, or designee, will identify documented behaviors on each resident being reviewed.	

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F 329	Continued From page 16 on all days of survey. Diagnoses included senile dementia, Alzheimer's disease, and dementia with behaviors. Current medications included Depakote 125 milligrams (mg) every morning and 250 mg every evening and Trazodone (an antidepressant) 50 mg once per day. Resident #1's current care plan stated, ". . . The resident has a behavior symptom R/T [related to] Dementia with behavioral disturbances E/B [evidenced by] hitting, kicking during cares. . . . Interventions . . . Behavior #1 hitting, kicking: approach in a calm manner. . . . The resident uses antidepressant medication R/T dementia with behavioral disturbances. . . . Interventions . . . Attempt non-pharmacological interventions such as diversional activities such as sensory stimulation, 1:1, quiet slow approach to cares, reapproach at later time, assess for possible pain. . . ." Nurses' notes identified an increase in Resident #1's behaviors with cares on 02/12/14; on 02/14/14, staff sent a urine sample to the lab. The urinalysis showed a urinary tract infection (UTI) for which staff treated Resident #1 with an antibiotic from 02/14/14 until 02/21/14. Resident #1's behavior log (completed by certified nursing assistants [CNAs]) from 01/24/14 to 03/18/14 identified eight episodes of physical behaviors/rejection of cares. Nurses' notes during this time identified two episodes of hitting at staff. Of these 10 documented behaviors, five incidents occurred during the period of time when Resident #1 had a UTI. A progress note, written by the mental health practitioner on 03/18/14, stated, ". . . Discontinue	F 329	Behaviors will be recorded on the revised Behavior Meeting worksheet. The meeting will focus on the mood/behaviors, possible causes/patterns, and resident specific interventions in the care plan, whether the interventions are being implemented, and whether or not they work. Opportunity for suggestion of new interventions will be provided. Care plan will be revised as needed. Behaviors will be tracked by keeping a binder of the Behavior meeting worksheets, organized by resident. Looking back at previous behaviors will provide a pattern to discern whether behaviors are increasing or decreasing. D) With each MDS/Care plan resident's behaviors will be identified, tracked and trended, monitored for patterns, development of interventions specific to the resident and his behaviors, and the care plan revised as needed.	

D 5/22/14

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F 329	Continued From page 17 the Ativan [an anxiolytic] - seems brighter - but with cares is hitting - slapping, kicking, and yelling while cares are performed - which is not her normal behavior . . . goal is activity without self harm . . . [increase] depakote sprinkles to 250 mg HS [bedtime] and 125 mg a.m. . . ." A progress note (written by social services), dated 04/11/14 at 12:30, stated, ". . . There are 3 reported instances of aggressive behavior on the kiosk. In talking with the CNA's, they say she is hitting, kicking, yelling, pinching every morning with cares. She is better once she gets in her chair and going for the day. She is often kind and appreciative then. The family doesn't want her back on Ativan. They want us to figure out a way to deal with her behaviors without it. Things that sometimes work: give her the dog while doing cares. She really likes it. She likes polka music and sometimes will sleep with it on. . . ." The behavior care plan failed to include these individualized approaches. Nurses' notes and CNA charting from 03/18/14 to 04/15/14 failed to identify either a deterioration or an improvement in Resident #1's behaviors after the increase in Depakote. During an interview on 04/16/14 at 10:27 a.m., a social services staff member (#5) stated she expected staff to document each time a behavior occurs. Resident #1's medical record failed to identify any tracking/monitoring of Resident #1's behavior (such as resistance to cares in the morning, evening, etc.) that would enable staff to better recognize patterns/precipitating or aggravating factors. The care plan lacked resident-specific	F 329	4. An audit tool will be developed to monitor staff in accurate documentation of all behaviors. The revised behavior meeting worksheet will be used as an audit to review interventions, see if they are being used, and effective in reducing the resident's behaviors. The DON, or designee, will complete the audit weekly x 2, monthly x 3, and quarterly through a year. Results will be reported to the DON, and will be submitted to the QA committee at scheduled meetings for additional recommendations. 5. Date in compliance	5/21/14

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F 329	Continued From page 18 approaches to minimize Resident #1's identified target behavior of resistance to cares. The behavior log as well as nurses' notes failed to identify implementation of non-pharmacological interventions attempted by staff to minimize the behaviors; as well as evaluation of the effectiveness of any non-pharmacological interventions attempted. The increase in Depakote on 03/18/14 without adequate indication may have resulted in Resident #1 receiving an unnecessary medication and experiencing adverse consequences related to its use.	F 329		
F 431 SS=E	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.	F 431	F 431 1. All Narcotic controlled schedule III-IV PRN meds are now counted every shift. 2. All Narcotic controlled schedule II meds (scheduled or PRN) and PRN Narcotic controlled III and IV meds will be signed out and counted when given, and also counted at every shift change.	

RJ
5/22/14

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F 431	Continued From page 19 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. This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, and staff interview, the facility failed to ensure periodic reconciliation (accurate account) of as needed (PRN) schedule III and IV controlled medications on 2 of 2 units (North and South). Failure to periodically reconcile PRN schedule III and IV controlled medications has the potential for medication loss or diversion of medications. Findings include: Review of the policy titled "CONTROLLED SUBSTANCES" occurred on 04/15/14. This policy revised February 2014, stated, "1. Weekly on Sunday, at shift change, 2 nurses count the controlled stock medications and record results in the narcotic book kept in the narcotic cupboard. 2. Records for controlled medications ordered for individual residents will be kept in a manuel [sic] with the count recorded with each dose administered. 3. Any new controlled drugs which are to be added to stock or a resident's supply will be recorded and stored appropriately by the nurse on duty at the time of delivery. . . ."	F 431	3. A) The Narcotic controlled medication procedure was revised and updated on 4/21/14. B) Charge nurses were educated in the Narcotic controlled medication procedure change on 4/22/14. 4. An audit tool will be developed to monitor staff to assure all PRN Narcotic controlled III and IV are counted every shift end. The DON, or designee, will audit weekly x 2, monthly x 2, and quarterly through a year. Results will be reported to the DON, and will be submitted to the QA committee at scheduled meetings for additional recommendations. 5. Date in compliance	5/16/14

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F 431	Continued From page 20 Observation on 04/15/14 from 2:00 p.m. to 2:30 p.m. of the North and South units, identified PRN medication cards contained controlled schedule IV medications (lorazepam and alprazolam). At this same time an interview with a licensed nurse (#2) verified that nurses do not count PRN controlled schedule III and IV medications. During an interview, on 04/16/14 at 9:30 a.m., an administrative nurse (#1) verified they do not have a system of accountability for PRN controlled schedule III and IV medications.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	F 441 1. Resident #16 and #17 will have the Blood Glucose machine disinfected after each use. 2. All Diabetic residents with Blood Glucose checks have the potential to be affected. 3. Charge nurses were re-educated on 4/23/14 in the Procedure for Disinfecting the Blood Glucose machines with each use.	

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F 441	Continued From page 21 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standard infection control practices during 3 of 3 observed blood glucose checks on two supplemental residents (Resident #16 and #17). Failure to follow infection control practices for disinfection of the glucometer after each resident use has the potential to spread infection to residents and staff. Findings include: Review of the facility policy titled " Cleaning and Disinfecting Blood Glucose Meters" occurred on 04/15/14. This policy, dated November 2011, stated, "NOTE: . . . This procedure is for cleaning and disinfecting a glucose meter when it is being used between multiple residents . . . Disinfecting NOTE: If a bleach solution is not used, it is also acceptable to use Steris Coverage Spray HB or Sani-Cloth Germicidal Disposable Wipe. . . ." During observations on 04/15/14 at 11:30 a.m.	F 441	4. An audit tool will be developed to monitor staff to assure Blood Glucose machines are disinfected properly after each use. The DON, or designee, will audit weekly x 2, monthly x 2, quarterly through a year, and PRN as needed. Results will be reported by the DON, or designee, to the QA committee at scheduled meetings for additional audit recommendations. 5. Date in compliance	5/16/14

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5/22/14

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GOOD SAMARITAN SOCIETY - MOHALL	602 E MAIN ST MOHALL, ND 58761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 22 with Resident #16 and at 11:35 a.m. and a recheck at 12:35 p.m. with Resident #17, a licensed nurse (#2) failed to disinfect the glucometer, stored on the medication cart, between resident use. During an interview, on 04/15/14 at 2:00 p.m., the licensed nurse (#2) stated she does not clean the glucometer between residents because the night nurse is responsible for daily cleaning of the glucometer. During an interview, on 04/15/14 at 3:45 p.m., an administrative nurse (#1) verified the nurse should clean the glucometer with disinfectant wipes after each resident use.	F 441		

5/22/14