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 _____	04/18/2013

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 started on April 16, 2013 and completed on April 18, 2013, the sample included 3 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000		
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure personal funds deposited with the facility were conveyed within 30 days of death for 1 of 2 resident accounts reviewed (Resident #13). This has the potential to affect all residents with personal funds in a resident account. Findings include: Review of the facility policy titled "Resident Trust Account General Information" occurred on 04/18/13. This policy, not dated, stated, "Resident Trust Account Refunds. Refunds must be issued when a resident expires or is discharged from the center. Refund checks should be issued	F 160	F0160 Resident #13's RFA balance paid out on 4-30-13. JB - changed on 5-22-13 per conversation w/ DON. 1. All Resident Fund Account (RFA) balances will be paid within 30 days of death to their representative. 2. All residents who have a RFA have the potential to be affected by this practice. 3. At least 2 x's monthly a resident fund balance report for discharged residents will be run, dated, and signed by business office personnel to check for any refunds to be paid. 4. The Quality Assurance Coordinator will audit monthly x 3 months, and then quarterly x 3 months, then as needed. 5. Date of correction was	4/30/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert J Sheeler — TITLE: Administrator — (X6) DATE: 5-17-2013

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
	355094	A. BUILDING _____ B. WING _____	04/18/2013

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 160	Continued From page 1 immediately at the time of death or discharge after accounting for outstanding transactions. No later than 30 days per CMS [Centers for Medicare and Medicaid Services]. . . . When a resident you are representative payee on discharges or dies, you must contact your local Social Security Administration Office. That office will instruct you on how to handle the refunding of any saved funds that the beneficiary had." Review of the accounting for conveyance of funds following death, occurred on 04/18/13 at 8:20 a.m., with an administrative staff member (#1). Review of resident trust fund account information identified the following: * Resident #13 expired on 11/20/12. The staff member (#1) identified the facility still maintained the resident's trust fund money of $827.94, 149 days later. During an interview on 04/18/12 at 8:20 a.m., an administrative staff member (#1) confirmed the facility failed to convey the resident's funds and a final accounting of the funds to the individual or probate jurisdiction administering the resident's estate, as required. The staff member (#1) identified Resident #13 converted to Medicaid in June 2012, and confirmed the resident did not owe the facility money. The staff member (#1) could not identify if the facility contacted the county of the resident's death, and could not determine if the trust account money would be returned to the county or to Resident #13's estate. Facility staff failed to convey the money in Resident #13's trust account and to notify the county as per policy, within 30 days of death.	F 160		
F 274	483.20(b)(2)(ii) COMPREHENSIVE ASSESS	F 274		

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 _____	04/18/2013

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 274 SS=D	Continued From page 2 AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) 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, and staff interview, the facility failed to complete significant change in status assessments (SCSA) for 3 of 3 sampled residents (Resident #3, #4, and #12) within 14 days after a significant change occurred in the resident's physical or mental condition. Failure to complete a SCSA in response to the resident's improvement or decline limited the facility's ability to accurately assess each resident's status, identify, and implement appropriate care plan approaches. Findings include: The Centers for Medicare and Medicaid Services (CMS) "Long-Term Care Facility RAI User's	F 274	F-274 1. For Resident #3: On 5-16-13 the MDS was reviewed for accuracy, and the care plan was updated to include the resident's current level of assistance with activities of daily living, ambulation/mobility/transfer, as well as current mood/behavior concerns. For Resident #12: The MDS was reviewed, and a Significant Change MDS will be completed with the next OBRA assessment with an ARD date of ~~6-4-13~~ 5-24-13. The care plan will be reviewed to ensure an accurate reflection of the resident's current level of assistance needed for toileting use, eating, personal hygiene, bathing, bed mobility, transfer, and dressing. For Resident #4: The MDS was reviewed and a Significant Change Unscheduled MDS will be completed with an ARD date of 5-21-13. The care plan will be reviewed to ensure that it accurately reflects resident's current level of assistance with bed mobility, transfers, and locomotion on and off unit, dressing, toileting use, and personal hygiene.	5-22-13 per conversation on phone with Darlee MDS coordinator.

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 _____	04/18/2013

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 274	Continued From page 3 Manual," Version 3.0, October 2012, pages 2-20 and 2-23 states, ". . . A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention . . . (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and /or revision of the care plan. . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g. [example given], two areas of ADL [activities of daily living] decline or improvement). . . ." - Review of Resident #12's medical record occurred on April 17-18, 2013. Diagnoses included osteoarthritis, muscle weakness, congestive heart failure, and edema. Resident #12's admission Minimum Data Set (MDS), dated 09/11/12, identified extensive assistance of one person for bed mobility, transfers, toilet use, and personal hygiene. The quarterly MDS, dated 12/04/12, indicated an improvement in these areas with independence in bed mobility, transfers, and toilet use, and limited assistance of one person in personal hygiene. The quarterly MDS, dated 03/04/13, continued to show the same improvements with the exception of the resident requiring setup assistance for transfers. The record lacked evidence staff completed a SCSA following Resident #12's improvement in four areas of functional status. - Review of Resident #3's medical record	F 274	2. All residents who have a significant decline or improvement in their status have the potential to be affected. 3. The Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual procedure and information involving Significant Change in Status Assessments (SCSA) will be reviewed by the DON, MDS Coordinator, and PTA by 5-28-13. System Change: The MDS Coordinator will review the Resident Kardex weekly to ensure a resident doesn't experience a significant change either for a decline or an improvement according to the RAI definition of a Significant Change in Status for a resident in the level of staff assistance in ADL's for all of the residents. 4. The MDS Coordinator will develop an audit to monitor for possible significant changes on MDS assessments every week x 4, then monthly x 2, then quarterly x 2, following with PRN audits as needed. If concerns are identified re-education will be implemented.	

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 _____	04/18/2013

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 274	Continued From page 4 occurred on all days of survey. Diagnoses included Down's syndrome, dementia, probable Parkinson's, seizure disorder, and hallucinations. Review of Resident #3's MDSs identified the following: * an admission, dated 08/03/12, identified extensive assistance needed with toilet use; limited assistance with eating, personal hygiene, bathing, and bed mobility; and only supervision with transfers and dressing. The resident did not require assistance to walk in room or corridor or for locomotion on and off the unit. * a quarterly, dated 10/31/12, identified a decline in the activities of daily living (ADLs) with extensive assistance needed transfers, dressing, eating, and personal hygiene. (A decline in two or more ADLs since the admission MDS) * a quarterly, dated 01/31/12, identified extensive assistance needed for bed mobility, transfers, walking in room and corridor, locomotion on and off the unit, dressing, eating, toilet use, personal hygiene, and bathing. (A decline in two or more ADLs from the previous quarterly MDS.) * a significant change assessment for decline completed on 02/12/13. The facility failed to complete the SCSA prior to 02/12/13 after the resident had declined from August 03, 2012 to October 31, 2012 and from October 31, 2012 to January 31, 2013. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included left hip fracture with surgery on 09/26/12, osteoarthritis, essential hypertension, and glaucoma.	F 274	The MDS Coordinator will submit a report of the monitoring results to the QA Committee at the scheduled meetings. 5. Date of correction will be	5/28/13

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 _____	04/18/2013

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 274	Continued From page 5 Review of the resident's MDSs identified the following: * a significant change for decline, dated 10/02/12, identified extensive assistance needed for bed mobility, transfers, locomotion on and off unit, dressing, toilet use, and personal hygiene. * a quarterly, dated 01/07/13, identified independence with bed mobility, locomotion on and off unit, toilet use, and personal hygiene, as well as limited assistance with dressing and staff supervision for transfers. (An improvement in two or more ADLs.) The facility failed to complete a SCSA for Resident #4's improvement in ADLs.	F 274		
F 281 SS=F	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 record review, review of professional reference, facility policy review, and staff interview, the facility failed to provide care in accordance with professional standards for 6 of 6 sampled residents (Resident #2, #3, #5, #7, #10, and #11) and one closed record resident (Resident #13) who experienced a fall with head trauma. Failure to complete a neurological assessment, or complete neurological exams per policy following a fall with head trauma has the potential for a head injury to go undetected. Findings include:	F 281	F-281 1. Resident(s) #2, #3, #5, #7, #10, and #11 do not have any residual neurological impairment, and did not experience a significant change due to fall. 2. All residents who have head trauma have the potential to be affected. 3. Charge Nurses in-serviced regarding Neurological Evaluation Procedure (March 2011) and GSS #497 Neuro Check Flow sheet (Jan 2011) on May 8th, 2013 at the All Staff Meeting. 4. The DON or designee will be responsible to audit/monitor	

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 _____	04/18/2013

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 281	Continued From page 6 Walters and Kluwar, Lippincott's Nursing Procedures, 5th Edition, 2009, pages 66-67 stated, "Managing Falls . . . Provide first aid for minor injuries as needed. Monitor the patient's status for the next 24 hours. Even if the patient shows no signs of distress or has sustained only minor injuries, monitor vital signs every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every 1 hour for 2 hours, or until his condition stabilizes. Monitor neurological assessments with vital signs, as per your facility protocol. . . ." Review of the facility policy titled "Falls Protocol" occurred on 04/17/13. This policy, dated 2/2013, stated, "Signs/Symptoms: . . . 2. Head trauma or highly probable head trauma . . . Check List . . . If Possible head injury, use neuro check flow sheet GSS [Good Samaritan Society] #497. Neuro checks @ [at] least initially & [and] q [every] 30 min. [minutes] x 2 [two times] and follow up approx. [approximately] 24 hrs. [hours] later. If known head injury or abnormal frequency follow neuro check flow sheet. . . ." Review of the "Neuro-Check Flow Sheet (GSS #497)" occurred on 04/17/13. This form dated, January 2011, stated, "Neuro-checks are to be performed with [the] following minimum frequency: Day 1: Every 30 minutes x 4 [four times], then every shift; Day 2: Every Shift; Day 3: Every Shift; Or more frequently as directed by physician." Review of the facility policy titled "Fallen or Injured Resident" occurred on 04/18/13. This policy, dated 10/2008, stated, ". . . 9. If a head injury is suspected, the charge nurse needs to	F 281	residents that fall and hit their head to ensure Charge Nurses have completed neuro checks weekly x 2 weeks, every 2 weeks x 1 month, monthly x 3 months, and quarterly through 1 year. Results will be immediately reported to the DON. If any concerns are identified, immediate corrective action will be taken. The DON or designee will submit a report of the monitoring to the QA Committee. 5. Date of correction	5/28/13

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 _____	04/18/2013

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 281	Continued From page 7 initiate a Neuro-Check Flow Sheet (GSS #497). . . ." - Review of Resident #5's medical record occurred April 16-18, 2013. Diagnoses included cognitive impairment with agitation, paranoia, and dementia with behaviors. The record showed Resident #5 had a history of falls. A nurse's note and incident report, dated 03/07/13, identified Resident #5 fell at 6:50 p.m., and sustained injuries, which included abrasions to the bridge of her nose. The incident report identified the resident hit her head. The "Neuro-Check Flow Sheet" (form dated 06/2008) showed nursing staff completed neurological checks (neuro-checks) on 03/07/13 at 6:50 p.m.; 7:20 p.m.; and 7:40 p.m. A nurse's note and incident report, dated 04/06/13, identified Resident #5 fell at 1:30 p.m. and sustained injuries, which included a bump to right side of her forehead, scratches and bruising to her upper right cheek and side of her right eye. Facility staff sent Resident #5 to the emergency room via ambulance at 2:55 p.m. Documentation failed to show nurses completed neuro-checks for Resident #5 following the fall. The "Neuro-Check Flow Sheet" (form dated 06/2008) showed nursing staff completed neuro-checks on 04/06/13 at 8:45 p.m. after Resident #5 returned from the emergency room at 8:40 p.m. - Review of Resident #10's medical record occurred on April 17-18, 2013, and identified a history of falls. An incident report, dated 10/31/12, identified	F 281		

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 _____	04/18/2013

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 281	Continued From page 8 Resident #10 fell at 9:10 p.m. and hit her head. The "Neuro-Check Flow Sheet" (form dated 06/2008) identified nursing staff completed neuro-checks on 10/31/12 at 9:10 p.m.; 11:20 p.m.; and on 11/01/12 at 9:10 p.m. An incident report, dated 12/15/12, identified Resident #10 fell, at 11:45 a.m., and hit her head. The report stated, "neuro checks were done." The "Neuro-Check Flow Sheet" (form dated 06/2008) showed no nursing entries for 12/15/12. Facility staff failed to perform neuro-checks per facility policy and failed to use the current GSS #497 form, dated January 2011 to perform neuro-checks for the known head injuries sustained by Resident #5 and #10. During an interview on 04/18/13 at 1:30 p.m., an administrative nurse (#2) agreed Resident #5 and #10's medical records lacked documentation of neuro-checks. - Review of Resident #2's medical record occurred on all days of survey. The Interdisciplinary Progress Notes identified the following: * 07/29/12 at 4:15 a.m., "Found [Resident #2] face down on [the] floor. [No] witnesses to fall. Bloody lip cleansed. Nose swollen. Gave PRN [as needed] Trazodone for [increased] agitation [with] staff [after] fall. Neuro[checks] initiated. . . ." * 07/29/12 at 9:00 a.m., "Cont [continued] [with] facial swelling cooperative [with] am cares. . . . To to [sic] send to ER [emergency room] via ambulance for facial trauma." * 07/29/12 at 10:10 a.m., "Ambulance left facility .	F 281		

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 _____	04/18/2013

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 281	Continued From page 9 . . ." * 07/29/12 at 5:10 p.m., "Returned to facility per ambulance [with] no new orders. Alert and restless. PRN Trazodone 50 mg [milligrams] given. At dinner table eating food." * 07/30/12 at 5:00 p.m., "[Increased] restlessness in AM took meds [medications] well [sic] restlessness [decreased] [No] aggression noted but did ref [refuse] vitals - would push away. . . ." The "Neuro-Check Flow Sheet" identified staff completed neuro-checks on 07/29/12 at 4:15 a.m., 5:00 a.m., 5:30 a.m. The resident was combative during the 4:30 a.m. attempt. Facility staff failed to perform neuro-checks per facility policy and failed to use the current GSS #497 form, dated January 2011 to perform neuro-checks for the known head injury sustained by Resident #2. - Review of Resident #7's medical record occurred all days of survey. Diagnoses included Alzheimer's disease. The annual MDS, dated 01/31/13, indicated the resident had no speech and rarely/never understood others. The record indicated Resident #7 fell and hit her head on the following occasions: * 02/12/13 at 5:20 a.m. - The nurses' notes and incident report identified a fall with a bruise to Resident #7's left eyebrow, and neuro-checks done. The record lacked evidence of neuro-checks. An administrative nurse (#2) failed to provide evidence of completed neuro-checks related to this fall. * 03/31/13 at 7:15 a.m. - The nurses' notes and incident report identified a fall with a "hematoma 4	F 281		

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 _____	04/18/2013

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 281	Continued From page 10 cm [centimeters] x [by] 3 cm" to the resident's head. The Neuro-Check Flow sheet showed staff completed neuro-checks on 03/31/13 at 7:15 a.m., 7:45 a.m., 8:15 a.m., 8:15 (possible wrong time) a.m., and on 04/02/13 at 4:00 p.m. Failure of facility staff to complete neuro-checks as indicated by facility policy may result in a head injury to go undetected. - Review of Resident #3's medical record occurred on all days of survey. A quarterly MDS, dated 01/31/13, indicated falls since admission and two falls included injury. Review of incident reports and nurses notes identified Resident #3 fell and hit his head on: * 11/12/12 at 11:15 a.m. - fell and obtained a small abrasion to his forehead and the corner of his eye. The Neuro-Check Flow sheet identified facility staff completed checks at 11:15 a.m. and 1:00 p.m. on 11/12/12. * 11/26/12 at 6:45 a.m. Facility staff found the resident on the floor between the bed and door in his room and the incident report noted no new abrasions but listed the abrasion from 11/12/12. The Neuro-Check Flow Sheet identified facility staff completed checks on 11/26/12 (no time listed) which identified the resident as "lethargic," and the next day two neuro-checks were completed: at 10:20 a.m. and a second check with no time listed. - Review of Resident #11's medical record occurred on 04/17/13 and 04/18/13. The progress notes and incident report identified Resident #11 fell on 06/05/12 and staff heard the resident calling out from the bathroom at 5:00 p.m. The	F 281		

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 _____	04/18/2013

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 281	Continued From page 11 resident obtained a three centimeter forehead laceration from the fall. The Neuro-Check Flow sheet identified neuro-checks completed at 5:15 p.m., 5:45 p.m., and 6:15 p.m. and on 06/06/12 with no time listed. A nurses note, dated 06/06/12 at 4:00 p.m., stated "No other problems noted from fall on 06/05/12." -Review of Resident #13's medical record occurred on 04/18/13. The progress notes and incident reports identified the resident fell on the following occasions and hit her head: * 06/25/12 at 7:45 a.m. Neuro-checks completed at 7:45 a.m., 9:10 a.m., 2:30 p.m., and 8:00 p.m. on 06/25/12 and on 06/26/12 at 9:00 a.m. * 09/24/12 at 1:00 p.m. Neuro-checks completed at 1:00 p.m., 1:45 p.m., 8:00 p.m. on 09/24/12 and on 09/25/12 with no time listed. During an interview on 04/18/13 at 10:40 a.m., an administrative nurse (#2) stated the facility decided to not complete the neuro-checks as per the revised corporate policy in January 2011 and the nurse stated the facility felt completing neuro-checks two times for the first 30 minutes and again 24 hours would be appropriate to monitor residents after a fall with head injury. The facility failed to ensure the neuro-checks were completed as per their corporate policy.	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.	F 309	F-309 Part 1: 1. A) Resident #1 expired. 2. A) All residents that experience uncontrolled pain have the potential to be affected.	

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 _____	04/18/2013

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 309	Continued From page 12 This REQUIREMENT is not met as evidenced by: 1. Based on observation, medical record review, review of facility policy, review of professional references, and staff interview, the facility failed to provide the necessary care and services to promote optimal well-being for 1 of 1 sampled resident (Resident #1) who experienced continued uncontrolled pain secondary to a femur fracture. Failure to inform the attending physician of the resident's continued uncontrolled pain did not allow the physician the opportunity to ascertain the cause of or prescribe treatment for her pain and resulted in Resident #1 experiencing avoidable pain. Findings include: Review of the facility policy titled "Pain Management - Resident Assistance" occurred on 04/18/13. This policy, dated January 2009, stated, "The registered nurse will assess current pain levels and develop with the physician . . . interventions which may be non-pharmacological as well as pharmacological. The registered nurse will review response to medication intervention and work closely with the physician to assist in the individualized pain measurement plan. . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included cerebral vascular accident, weakness, aphasia, anxiety, depression, rheumatoid arthritis, osteoporosis, contractures of hands and feet, tophi (benign fatty tumor) gout to left elbow, and	F 309	3. A) Nursing Staff were in-serviced on 5-8-13 to re-educate staff with the focus to notify the Primary Attending Physician when other Medical Practitioner's medical orders do not alleviate the resident's physical pain, or adequately address other medical needs. 4. A) An audit tool will be developed to monitor residents with uncontrolled pain and to ensure Charge Nurses will notify the Primary Attending Physician if pain appears uncontrolled, or a medical condition does not seem to be improved. The DON or designee will be responsible to audit weekly x 4 weeks, then every 2 weeks x 1 month, then quarterly x 2, then PRN. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QA Committee at scheduled meeting. 5. Date in compliance	5/28/13

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 _____	04/18/2013

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 309	Continued From page 13 left knee supracondylar femoral fracture. The significant change Minimum Data Set (MDS), dated 03/02/13, identified Resident #1 had short/long-term memory deficits and moderately impaired problem solving skills. She also required extensive-to-total assistance of one or more persons for bed mobility, transfers, locomotion on/off unit, dressing, and toileting. The MDS further identified Resident #1 expressed her pain non-verbally (through her body/posture) and/or verbally, and her pain was managed through scheduled pain medications, PRN (as-needed) pain medications, and/or other non-pharmacological interventions. (The previous MDS, dated 11/30/12, identified Resident #1 presented with no pain, and received scheduled pain medications.) The Resident Care Area Assessments (CAAs), dated 03/18/13, identified the following: * Communication: ". . . She is aware of her wants and needs but has very slurred/garbled speech and has difficulty making these needs known to staff. . . ." * Activities of Daily Living (ADLs): ". . . She may respond yes/no to direct questions. . . . [Resident #1] continues to need physical support with all cares due to mobility impairment . . ." * Falls: ". . . She is non-ambulatory and transfers only with total lift as her balance is poor and she is not able to stand flat on her feet. [Resident #1] has had pain/swelling to her left knee, which has worsened when she would stand and bear weight. She since has had her leg x-rayed and a fracture was identified. . . . She did need to be lowered to the floor 12/08[/12] as she was slipping from her w/c [wheelchair]. . . ."	F 309	F-309 Part 2: 1. B) Resident #7's bowel assessment was reviewed and revised, and Prune juice daily was started on 4-18-2013 to promote regular bowel elimination. The care plan was updated. 2. B) Any Resident without a BM on day 3 has the potential to be affected. 3. B) System Change: A new Bowel Protocol was developed, and Charge Nurses were in-serviced on May 8th, 2013 at the All Staff Meeting. 4. B) Charge Nurses will be responsible to implement the new Bowel Protocol, and make sure it is followed. The DON or designee will audit weekly x 1 month, every 2 weeks x 1 month, monthly x 2 months, quarterly x 2, then PRN. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The DON or designee will submit a report to the QA Committee at scheduled meeting. 5. Date to be in compliance	5/28/13

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 _____	04/18/2013

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 309	Continued From page 14 * Behavioral Symptoms: ". . . She has had acute pain to her left knee which has distressed her and may have impacted her mood and anxiety level as well. During this time, she would would [sic] not allow staff to touch her leg. . . . [Resident #1] does does [sic] have [a] history of yelling out loudly, sometimes repeatedly. The yelling does not always seem to signify need . . ." * Psychotropic Drug Use: ". . . [Resident #1] does also take Ativan 0.5 mg [milligrams] at 3 pm daily d/t [due/to] increased agitation. She does have a[n] Ativan 0.5mg prn [as needed] does [sic] that has been given approximately 3x week during February d/t agitation, increased restlessness and yelling out. She has received prn doses of Ativan 0.5mg x 4 this past month for increased yelling/agitation/restlessness. Note that this medication does not always give her relief. . . ." * Pain: ". . . [Resident #1] did present with pain to her left knee, with increased warmth, swelling, redness and refusing to bear weight on her left leg during transfers. She has subsequently been identified as having a left femur fracture. An order for Duragesic patch 25mcg [micrograms] was received 2/18[/13]. [Resident #1] does continue to take previous order for Tylenol 650mg tid [three times daily]. . . . She does seem to be getting good pain relief with the addition of wearing an immobilizer in addition to her medications. . . ." The temporary narrative care plan, dated 03/11/13, and the current comprehensive care plan identified, ". . . Problem: Potential for injury r/t [related to] impaired mobility . . . Approaches: Total lift [with] assist of [two] staff . . . Needing gerichair for positing [sic]/comfort . . . Problem: Fracture to left femur . . . Approaches: . . . Continue total lift, No wt [weight] bearing, See	F 309		

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 _____	04/18/2013

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 309	Continued From page 15 Orthopeadic [sic] MD, Control pain . . . Keep immobilizer on to left leg as ordered . . . Problem: Self-care deficit . . . Approaches: Needs total staff assist with all ADLs including bathing, grooming, dressing, toileting, mobility, [and] locomotion . . . Problem: Alteration in comfort r/t fx [fracture] to left femur . . . Approaches: Medicate as ordered . . . Offer non-medicine interventions for pain relief: position change . . ." The Medication Administration Record (MAR) identified the following: * Lexapro 20 mg daily used to treat depression/anxiety (Ordered 03/02/12) * Methotrexate 25 mg every week used to treat rheumatoid arthritis (Ordered 03/02/12) * Trazodone 100 mg every HS [at bedtime] used to treat depression/insomnia (Ordered 03/02/12 - Discontinued 03/18/13 - Reordered 03/20/13) * Tylenol 650 mg TID [three times daily] used to treat mild pain (Ordered 03/02/12) * Tylenol 650 mg BID [twice daily] PRN (Ordered 03/02/12) * Ativan 0.5 mg every 6 hrs PRN used to treat anxiety/insomnia (Ordered 03/15/12) * Ativan 0.5 mg at 3:00 p.m., ordered 01/24/13. On 03/18/13, increased to TID "for increased agitation" * Ativan 1.0 mg at HS (10:00 p.m.) (Ordered 03/18/13 - Discontinued 03/20/13) * Indomethacin 25 mg daily x [times] 1 week used to treat rheumatoid/gouty arthritis (Ordered 01/28/13 - Discontinued 02/04/13) * Vicoprofen 1 tab every 4-6 hours PRN used to treat severe pain (Ordered 02/04/13 - Discontinued 02/18/13) * Duragesic 50 mcg - change every 72 hours used to treat moderate-to-severe chronic pain	F 309		

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 _____	04/18/2013

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 309	Continued From page 16 (Ordered 04/03/13 - increased from 25 mcg beginning 02/18/13) The PRN medication notes, dated 01/03/13-01/26/13, identified staff administered Ativan on 20 occasions due to the resident being "agitated, restless, resistive to cares, and for yelling, hollering, and/or screaming." No PRN pain medications were administered during this same time period. The PRN medication notes, dated 01/27/13-04/01/13 further identified staff administered: * Ativan due to the resident being "increasingly anxious, agitated, and restless, and for moaning, calling/yelling out, hollering, and/or screaming" on 32 occasions. * Tylenol due to the resident "moaning, calling out, and hollering, to provide for/promote comfort, and due to questionable left knee pain" on 10 occasions. * Vicoprofen due to the resident "yelling and screaming, due to left knee/leg pain, and to promote comfort in the left leg during ADLs" on 20 occasions. * Ativan and Tylenol at the same time on five occasions. * Ativan and Vicoprofen at the same time on two occasions. See F329. The interdisciplinary progress notes identified the following: * 12/08/12 at 4:20 p.m., "Sitting [at] edge of w.c. [wheelchair] Staff lowered [Resident #1] to the floor. Unable to reposition back in chair before she started to slide. [No] injuries."	F 309		

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 _____	04/18/2013

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 309	Continued From page 17 * 12/14/12 at 12:00 p.m., "Seen at Center by [physician] for 60-day med [medication] review condition remains stable. . . ." * 01/24/13 at 12:30 p.m., ". . . Discussed agitation daily that has required prn [as needed] Ativan to be given 16 of past 24 days. Ativan order obtained that will be scheduled at 3 p.m." * 01/25/13 at 11:00 p.m., "Resident had [increased] agitation throughout the evening. PRN Ativan given at 7:00 p.m. . . . No results occurred. Resident still agitated. Readjusted resident in bed. . . . CN [Charge Nurse] talked [with] resident to try and calm her down. Did not work. Will continue to monitor for [increased] agitation and if needed will give prn q [every] 6 hr [hours] Ativan at 1:00 a.m." * 01/26/13 at 7:00 a.m., "Cont. [continued] [to be] agitated and calling out espec [especially] [with] cares. Ativan admin [administered] for agitation. Tylenol 650 mg admin for comfort. . . ." (The interdisciplinary progress notes, dated 12/08/12-01/25/13, identified Resident #1 made no complaints of pain.) * 01/26/13 at 9:00 a.m., ". . . Has been quiet except during scheduled cares becomes easily agitated. Calms [after] cares completed. . . ." * 01/27/13 at 2:00 p.m., ". . . Direct staff reported [Resident #1] c/o [complained of] pain to (L) [left] leg. Examined noting (L) knee [increased] warmth, swelling, [and] redness. [Resident #1] does not want to bear weight on this leg. Will monitor [and] send to clinic tomorrow. . . ." * 01/28/13 at 3:00 a.m., ". . . Lt [left] knee slightly red and warm." * 01/28/13 at 6:00 a.m., "[Resident #1] resting in bed. . . . No sign of pain or distress. L [left] inner knee pink - warm to touch - sl [slightly] swollen." * 01/28/13 at 9:00 a.m., "[Increasingly] diaphoretic	F 309		

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 _____	04/18/2013

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 309	Continued From page 18 . . ." * 01/28/13 at 5:00 p.m., "[Resident #1] is restless [and] [has] [increased] anxiety as evidenced by yelling [and] [increased] sweating to face . . . L knee remains swollen [and] red. Tender to touch. . . ." Upon request on 04/18/13, the facility obtained copies of the "Clinic Notes" signed by the Family Nurse Practitioner (FNP). See F514. The 01/28/13 "Clinic Note" identified, ". . . Present Illness: . . . left knee redness and swelling. Pt [patient] will scream out when the left leg is moved and she does not want to put any weight on it during transfers. . . . Plan: . . . Indomethacin [an anti-inflammatory used to treat gouty arthritis] x [times] one week. . . . Nurses are to inform me of any worsening symptoms. . . ." The interdisciplinary progress notes further identified: * 01/29/13, "Cont. to note Lt knee to be larger than Rt [right]. Also note fading bruising behind knee. . . ." * 02/03/13 at 4:00 p.m., "Med [medicated] [Resident #1] 2 x [with] Tylenol for pain of L leg [question] L Leg is swollen [above] [and] [below] knee . . . Shakes head yes when questioned if having pain. . . ." * 02/04/13 at 2:30 p.m., "Cont to hollor [sic] this am - asked if in pain [and] shrugs shoulders no - to CNA nodded head yes to gen. [general] ache all over. . . . Taken to clinic in w/c by staff [and] returns the same [without] problem. L Leg swollen to knee [above] [and] [below] . . ." From 01/28/13 to 02/04/13, the medical record identified Resident #1's left leg was red and	F 309		

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 _____	04/18/2013

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 309	Continued From page 19 swollen above and below the knee. Her left knee was larger than the right, with fading bruising behind it. Her left leg was tender to the touch, as evidenced by her shaking her head yes in response to questions, moaning, calling/yelling out and/or sweating. She also experienced increased anxiety and restlessness. The 02/04/13 "Clinic Note, "signed by the FNP, identified, ". . . Present Illness: . . . followup of . . . gouty arthritis. . . . Pt was given . . . indomethacin. There was really no update on the nursing home clinic referral, so I did phone over to the nurse on duty and [she] reports that she feels the redness is better but the swelling remains and pt will cry out in pain when the left leg is touched. She does not feel that the indomethacin helped pt that much. . . . Plan: . . . vicoprofen 1 tablet every 4-6 hours prn pain to see if we can get her pain under control. . . . Nursing home (NH) staff will notify me of her pain status. . . . NH staff may use warm moist heat applications prn throughout the day and monitor the knee for increased redness. . . . FU [follow up] in 2 weeks to assess left knee." From 02/04/13 to 02/08/13, the medical record identified Resident #1's left leg was deviated slightly inward, and very tender when moved as evidenced by her red, sweaty face, moaning, and/or screaming/yelling. The interdisciplinary progress note, dated 02/08/13 at 4:00 p.m., identified, "[Resident #1] this a.m. was screaming [and] yelling. Vicodin [and] Ativan was given because [Resident #1] was so worked up. Face was red [and] was pure sweat. Noting that [Resident #1's] Lt knee was very tender when moved. A Fax was sent to . . .	F 309		

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 _____	04/18/2013

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 309	Continued From page 20 Clinic concern[ing] [Resident #1's] Lt knee. Noting it to be slightly deviated inward. . . . [Resident #1] was medicated [with] PRN pain med x's [two] today along [with] scheduled Tylenol. Warm moist paks [sic] were applied as scheduled. Will continue to monitor." The 02/08/13 "FAX Communication to Physician" note, signed by the FNP, identified, ". . . Concern: Cont. to have [increased] pain to Lt knee. Does scream [and] yell out. Noting this am when laying in bed that the knee is deviated inward. Will not allow her foot to be up on leg rest will yell out [and] scream. . . . Response: . . . Cont [with] pain meds. . . ." The 02/08/13 "Clinic Note," signed by the FNP, identified, ". . . Present Illness: . . . with acute flare up of the RA [rheumatoid arthritis] and also some gouty type of arthritis to left knee. . . . She presented to the clinic on 1-28-13 with an erythemic, very swollen left knee and increased bouts of hollering out when she was moved. I treated her with an . . . antiinflammatories [sic] with resolution of her erythema. The left knee continues to be swollen and the staff reports that any time she is touched to be repositioned she hollars out like she is in a lot of pain. She has been getting prn Vicoprofen with little relief. . . . Plan: . . . Duragesic patch 25 micrograms to be changed every 72 hours. . . . Discontinue Vicoprofen in 24 hours. . . . Nursing staff is to report to me if no relief of pain . . . FU prn . . ." The interdisciplinary progress notes further identified: * 02/14/13 at 4:30 p.m., "TC [telephone call] to . . . [FNP] to discuss pain and deteriorating condition	F 309		

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 _____	04/18/2013

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 309	Continued From page 21 r/t L knee pain. Knee deviated medially. She does not put weight on leg. . . . [FNP] states [Resident #1] would not tolerate an xray to be done [at local clinic] . . . . Xray could be done in [near-by town]. CN will assess condition over the next few days [and] call her if needed to schedule xray. . . ." * 02/15/13 at 10:00 a.m., "Held hot packs to (L) knee. N.O. [new order] to try ice packs to see if this helps her more . . ." * 02/15/13 at 2:00 p.m., "Evaluated by PT [Physical Therapy] this a.m. d/t [increased] pain to Lt knee. PT recommends use of total lift [with] assist of [two] staff. . . ." * 02/16/13 at 10:00 a.m., "TC to [family member] . . . Discussed pain management. We both agree that the pain is not well controlled. [FNP] had agreed that she may need Fentanyl Patches to improve control of pain. . . . Fax sent to [FNP] to request this." From 02/08/13 to 02/16/13, the medical record identified Resident #1's left leg was deviated medially. Resident #1 refused to bear weight on her leg, and the Physical Therapist recommended she be transferred with a full body lift and assist of two. The resident's pain was not well controlled as evidenced by her continued screaming/yelling, increased agitation, and guarding/tensing. The facility sent a "FAX Communication to Physician" on 02/16/13 which stated, ". . . Concern: Pain continues to not be controlled well - she yells with cares and during NOC - she guards herself [and] tenses up. We had discussed the possible need for fentanyl patch. Could we trial that? I discussed this with her daughter [and] she would like to see her mom more comfortable. . . . Response: [No response	F 309		

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 _____	04/18/2013

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 309	Continued From page 22 noted.] . . ." The form was signed off by the FNP. The interdisciplinary progress notes further identified: * 02/18/13 at 11:50 a.m., "[FNP] from Clinic came to see [Resident #1] - [Resident #1 is resting in bed comfortably. L knee swollen, sl warm to touch . . . Screams when Rt leg moved so could see L knee better. Also - sweaty at this time but [no] temp [temperature]. . . ." * 02/19/13 at 3:00 p.m., "Duragesic Patch has helped [Resident #1] today. . . . Did shout during bath - transf [transferred] by total lift. . . ." * 02/21/13 at 5:00 p.m., "Cont. [to be] more content. [Less] calling out. She did call out during transfer this [after]noon, but quieter when sitting in w/c. . . ." * 03/05/13 at 4:00 p.m., "[Resident #1] cont to yell [and] scream during cares [and] at x's when just sitting in her room. When asked what is wrong she is unable to express to staff what is [wrong]. When staff moves her Lt leg [and] even go to look at it, [Resident #1] will scream [and] yell out. A fax was sent to [FNP]. . . ." From 02/18/13 to 03/05/13, the medical record identified Resident #1 was sweaty and her left leg was slightly warm and swollen. The resident would scream/yell out when staff moved and/or "even looked at her leg." The facility sent a "FAX Communication to Physician" on 03/05/13, which stated, ". . . Concern: [Resident #1] cont. to yell out [and] scream during ADL[s] or any cares. Also will sit in her rm [room] [and] scream. When asked if she has pain she is not able to tell us. Any pressure or movement to Lt leg she will scream. Can we get	F 309		

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 _____	04/18/2013

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 309	Continued From page 23 an order for an x-ray to her Lt knee . . . Response [by the FNP]: . . . Have [Physician] evaluate on next visit. . . ." The interdisciplinary progress notes further identified: * 03/06/13 at 9:00 a.m., "Receive TC from [Resident #1's family member] [and] family stated if [physician] wishes [Resident #1} to have an x-ray they would agree to that. . . ." * 03/06/13 at 4:50 p.m., ". . . TC was made it [sic] [Physician] [and] orders were received. . . ." * 03/08/13 at 12:50 a.m. [sic], "Left in w/c - facility van for x-ray . . ." The radiology report, dated 03/08/13, identified, ". . . 1. Fracture of the distal femur at the femoral component of the left knee arthroplasty. 2. The fracture is angled. . . ." The facility contacted Resident #1's physician directly on 03/06/13. The resident's physician ordered an x-ray of her left leg (completed on 03/08/13). The x-ray showed a left distal femur fracture. The interdisciplinary progress notes further identified: * 03/09/13 at 3:00 p.m., "Calling out during bath - [question] pain to L knee. Tylenol 650 mg given - Ice pack applied [with] some relief. . . ." * 03/11/13 at 10:30 a.m., "TC from [Physician's] office x-ray from 03/08/13 shows a (L) distal femur fx [fracture]. Recommendations are to see an orthopedic ASAP [as soon as possible]. . . ." A FAX sent to the facility and signed by the physician, dated 03/11/13, identified, "Pt needs	F 309		

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 _____	04/18/2013

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 309	Continued From page 24 ortho[pedic] consult for (L) distal femur fx. . . . Consult [with] [Physician] ASAP! . . ." The "Clinic Referral" signed by the physician, dated 03/13/13, identified, "Problem . . . (L) distal femur fx - evaluate/treat . . . Orders: . . . Maintain (L) knee immobilizer all the time except skin care . . ." The "Rural Mental Health Geriatric Progress Evaluation," dated 03/18/13, identified, ". . . History: Hollaring [sic] - fx (L) [lower] femur - sleep is so irratic[sic] it is not possible to document . . . "anxiety - yelling - screaming rejecting of care [with] being short tempered . . . Plan: D/C Trazadone 100 mg . . . q HS, Ativan 0.5 mg tid and 1 mg . . . q HS. . . ." The interdisciplinary progress notes further identified: * 03/21/13 at 4:30 p.m., "This a.m. [Resident #1] was given a Geri-chair [reclining wheelchair] for positioning. In w/c [Resident #1's] position was slouch[ed] over [and] always leaning to R [right] side [and] siding [sic] down in w/c. After being placed in the Geri-chair, [Resident #1's] position was much better [and] had [no] yelling out. Was comfortable. . . ." * 03/23/13 at 2:00 p.m., ". . . [Resident #1] wears [an] immobilizer all the time now. . . ." * 03/30/13 at 5:30 a.m., "Yelling and calling out this a.m. Immobilizer applied so strap is over knee. This seemed to help as her yelling stopped. . . ." * 04/01/13 at 12:00 a.m., "Cont to yell out all NOC [night]. Medicated [with] PRN Ativan [and] scheduled Tylenol with [no] improvement. Rep [repeated] q 2 hrs but cont to yell out. Fax was	F 309		

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 _____	04/18/2013

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 309	Continued From page 25 sent to [Physician] regarding possible [increase] in pain. . . ." * 04/01/13 at 5:00 p.m., "Med 3 x [with] tylenol - did shout off [sic] [and] on until 7:00 a.m. . . ." * 04/01/13 at 11:00 p.m., "Res [Resident] yelling [and] [has] [increased] agitation. Res gets self worked up to become so she is diaphoretic . . . Removed immobilizer for 5 mins [minutes] then reapplied. . . . Medicated [with] PRN Ativan 0.5 mg [and] scheduled Tylenol 650 mg. . . . later some relief - not yelling loudly. [Physician] notified via fax of possible increased pain. He's out of the office till 04/03/13." * 04/03/13 at 3:00 p.m., "Rec'd [received] fax from [Physician] . . ." The facility sent a "FAX Communication to Physician" on 04/03/13, which stated, ". . . Concern: I do not think we have good pain control. [Resident #1] yells out frequently on [and] off during day. She grimaces and straightens out her body . . . She becomes [increasingly] pale and profusely diaphoretic. . . . Response [by the physician]: . . . Increase duragesic to 50 mcg patch . . ." Observation showed the following: * 04/17/13 at 8:20 a.m., two Certified Nursing Assistants (CNAs) (#3 and #4) repositioned Resident #1. She stated, "Ah, ah, ah" in a raised voice when the CNAs readjusted the pressure relieving boot on her left foot and placed a pillow under her left leg (which was in an immobilizer). She slept prior to and following cares. During an interview on 04/17/13 at 3:30 p.m., an administrative staff member (#2) stated, "We sent her [Resident #1] over, and talked to her [FNP].	F 309		

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 _____	04/18/2013

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 309	Continued From page 26 She wouldn't order an x-ray, so we called him [Physician]." When asked why the facility failed to contact the physician sooner, the administrative staff member (#2) stated, "She [FNP] thought it was gout or arthritis." Although the facility contacted the FNP at the clinic, they failed to inform Resident #1's attending physician of her continued uncontrolled left knee pain as evidenced by: * her left leg being pink/red, warm, and swollen above and below the knee * her left leg deviating medially * her refusal to bear weight on her left leg which resulted in staff using a whole body lift for transfers * her left knee being tender to the touch and/or painful as evidenced by her red, sweaty face, moaning and/or screaming and yelling out when staff moved and/or "even looked at" her leg. * her increased anxiety and restlessness, requiring stronger pain medications and increased doses of both her anti-anxiety and pain medications - staff administered anti-anxiety and pain medications at the same time on seven occasions The facility's failure to inform the attending physician of Resident #1's continued uncontrolled pain, did not allow him the opportunity to ascertain the cause or prescribe treatment and resulted in Resident #1 experiencing avoidable pain. Resident #1 expressed discomfort/pain in her left leg beginning on 01/27/13, and her femur fracture was not diagnosed until 03/08/13 (41 days later). 2. Based on record review and staff interview, the	F 309		

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 _____	04/18/2013

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 309	Continued From page 27 facility failed to provide interventions to promote regular bowel elimination for 1 of 7 sampled residents (Resident #7) with a diagnosis of constipation. Failure to follow a bowel protocol and provide dietary interventions to relieve constipation has the potential to cause the resident unnecessary discomfort. Findings include: Review of Resident #7's medical record occurred on all days of survey. Diagnoses included constipation and Alzheimer's disease. The annual Minimum Data Set (MDS), dated 01/31/13, indicated no speech, rarely/never understands others, severely impaired decision making ability, extensive assistance of two or more people for toileting, frequently incontinent of urine, and continent of bowel. The quarterly MDS, dated 10/31/12, indicated the resident was frequently incontinent of urine and bowel. Medications included "bowel care of choice" as needed (PRN) for constipation, ordered 10/22/11. Resident #7's care plan, dated 02/14/13, included the problem "Potential for pain/discomfort r/t [related to] . . . constipation . . . Goals: . . . Will be free of constipation. Plans and Approaches: . . . Reports/record BM (bowel movement) accurately . . ." The care plan failed to include specific interventions to manage constipation, including dietary interventions. During an interview on 04/18/13 at 8:10 a.m., when asked how the dietary department is made aware a resident has constipation issues, a dietary supervisor (#12) stated, "Nursing will write a slip for prune juice or prune sauce." This	F 309		

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 _____	04/18/2013

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 309	Continued From page 28 supervisor stated dietary had not been informed of Resident #7's problem with constipation. During an interview on 04/18/13 at 10:15 a.m., when asked for the facility bowel protocol, a nurse administrator (#2) stated they follow an unwritten protocol where on the third day of no BM, the nurse gives the resident a bowel stimulant of the resident's choice or per physician order. The night nurse lists all residents with no BM in two days and three days. The day nurse's protocol is to give suppositories between 5:15 to 5:45 a.m. This nurse stated Resident #7 receives a suppository because she does not take medication well, spits out pills occasionally, and the suppository works best. Resident #7's bowel record showed the absence of a BM on the following days and the Medication Administration Record (MAR) showed laxatives provided and their effect: * January 8-10 = 3 days. Dulcolax suppository (supp) on 01/11/13 (day 4) with results. Staff failed to give a bowel stimulant on day 3. * January 12-14 = 3 days. Dulcolax supp on 01/15/13 (day 4) with no results until 01/16/13. Staff failed to give a bowel stimulant on day 3. * January 17-21 = 5 days. Dulcolax supp on 10/20/13 (day 4) with no results and Dulcolax supp on 01/22/13 (day 6) with results. Staff failed to give a bowel stimulant on day 3 and day 5. * January 23-26 = 4 days. Dulcolax supp on 01/27/13 (day 5) with results. Staff failed to give a bowel stimulant on day 3 and day 4. * January 28-30 = 3 days. Dulcolax supp on 01/31/13 (day 4) with results. Staff failed to give a bowel stimulant on day 3. * February 7-9 = 3 days. Dulcolax supp on	F 309		

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 _____	04/18/2013

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 309	Continued From page 29 02/10/13 (day 4) with results. Staff failed to give a bowel stimulant on day 3. * February 11-14 = 4 days. Dulcolax supp on 02/15/13 (day 5) with results. Staff failed to give a bowel stimulant on day 3 and day 4. * February 22-24 = 3 days. Dulcolax supp on 02/25/13 (day 4) with results. Staff failed to give a bowel stimulant on day 3. * February 28-March 2 = 3 days. Dulcolax supp on 03/03/13 (day 4) with results. Staff failed to give a bowel stimulant on day 3. * March 4-6 = 3 days. Dulcolax supp on 03/07/13 (day 4) with "good results . . . hard, so gave MOM [milk of magnesia] 15 ml [milliliter]." MOM given 03/07/13 with small results." Staff failed to give a bowel stimulant on day 3. * March 8-10 = 3 days. Dulcolax supp on 03/11/13 (day 4) with results. Staff failed to give a bowel stimulant on day 3. * March 12-14 = 3 days. Dulcolax supp on 03/15/13 (day 4) with results. Staff failed to give a bowel stimulant on day 3. * March 16-18 = 3 days. Dulcolax supp on 03/19/13 (day 4) with results. Staff failed to give laxative on day 3. * March 20-22 = 3 days. Dulcolax supp on 03/23/13 (day 4) with results. Staff failed to give a bowel stimulant on day 3. * March 24-26 = 3 days. Dulcolax supp on 03/27/13 (day 4) with results. Staff failed to give a bowel stimulant on day 3. * March 30-April 1 = 3 days. Dulcolax supp on 04/02/13 (day 4) with results. Staff failed to give a bowel stimulant on day 3. * April 5-7 = 3 days. Dulcolax supp on 04/08/13 (day 4) with results. Staff failed to give a bowel stimulant on day 3. * April 13-16 = 4 days. Dulcolax supp on 04/17/13	F 309		

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 _____	04/18/2013

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 309	Continued From page 30 (day 5) with results. Staff failed to give a bowel stimulant on day 3 and day 4. Staff failed to administer a bowel stimulant to Resident #7 on 22 of the above occasions when the facility protocol required action due to three or more days without a BM. The facility failed to implement other interventions, such as additional fluids, scheduled bowel stimulants, or dietary interventions to promote effective elimination and reduce the necessity of frequent suppository use, which could lead to discomfort.	F 309		
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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/19/12. Based on observation and policy review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 3 of 7 sampled residents (Resident #2, #3, and #8) observed transferred with a gait belt. Failure to properly use a gait belt placed the residents at risk for sustaining a fall and/or injury.	F 323	F-323 1. Resident #2, #3, and #8 will have gait belt placed properly when transferred according to facility procedure. 2. All residents who need physical assistance when transferring have the potential to be affected. 3. Certified Nursing Assistants were in-serviced with the focus on proper gait belt application, and a demonstration of proper gait belt application was performed by the Physical Therapy Department at the All Staff Meeting on May 8th, 2013.	

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 _____	04/18/2013

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 323	Continued From page 31 Findings include: Review of the facility policy titled "Gait (Transfer) Belt" occurred on 04/18/13. This policy, revised January 2009, stated, "Purpose: To safely transfer or ambulate resident; To aid resident in maintaining balance; To avoid injury to both resident and staff member. NOTE: Gait belts are used unless medically contraindicated. Procedure: . . . 2. Place belt around resident's waist over clothing, . . . 4. Make sure belt is securely buckled so it does not slide. Belt should not be twisted and should be just snug enough so you can get your fingers under it. . . ." - Review of Resident #2's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 03/01/13, identified extensive assistance required for transfer and walking in room/corridor. On 04/17/13 at 8:10 a.m., observation showed two CNAs (#3 and #4) applied a gait belt to Resident #2. One CNA (#4) stood on the resident's right side and held onto the gait belt, as the other CNA (#3) stood on his left side and held onto his arm. The CNA (#3) failed to transfer Resident #2 using the gaitbelt. - Review of Resident #3's medical record occurred on all days of survey. A significant change MDS, dated 02/12/13, identified extensive assistance of two people required for transfers. Observation on 04/17/13 at 10:22 a.m. showed two CNAs (#3 and #4) assisted Resident #3 from his wheelchair, onto the toilet, and back to his wheelchair. During the transfers, a gaitbelt,	F 323	4. All staff physically assisting residents with transfers or ambulation are responsible to use gait belts correctly. The DON or designee will audit proper application of the gait belt by staff weekly x 2, then every 2 weeks x 2, then monthly x 2, quarterly thru the year, then PRN. Results will be reported to DON. If concerns are identified, immediate corrective action will be implemented. The DON or designee will submit reports to the QA Committee at scheduled meetings. 5. Date to be in compliance	5/28/13

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 _____	04/18/2013

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 323	Continued From page 32 applied loosely around the resident's waist, slid up his chest and under the resident's axillas. The CNA's failed to adjust the gaitbelt during the transfers to prevent it from sliding up. - Review of Resident #8's medical record occurred on all days of survey. The annual MDS, dated 02/09/13, identified extensive assistance of two or more people required for transfers. On 04/17/13 at 1:56 p.m., observation showed two certified nurse aids (CNAs) (#7 and #8) wheeled Resident #8 into the bathroom, loosely applied a gait belt in the area under the resident's axilla, above her breasts. The CNAs assisted Resident #8 to stand holding the gaitbelt and under the resident's arms. The gaitbelt pulled up on the resident's axilla while the CNAs transferred the resident to the toilet. The resident ended up sitting sideways on the toilet. One CNA (#7) removed and reapplied the gait belt securely, but again placed it on Resident #8's chest, under her axilla, and above her breasts.	F 323		
F 329 SS=E	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	F 329	F-329 1. A) Resident #3 was evaluated by Vickie Weathers CNS (Facilities Psychiatric Nurse Practitioner) on 5-13-13 for a Gradual Dose Reduction (GDR).	

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 _____	04/18/2013

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 329	Continued From page 33 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 4 of 7 sampled residents (Resident #1, #3, #7, and #10) receiving scheduled and/or as needed (prn) antianxiety medications and for 1 of 5 sampled residents (Resident #2) receiving prn antipsychotic medications. Failure to periodically re-evaluate the necessity of antianxiety medications and attempt gradual dose reductions (GDRs) (unless contraindicated); failure to distinguish between a resident's need for pain medication or antianxiety medication; and failure to attempt non-pharmacological interventions prior to administering a psychotropic medication, placed residents at risk of receiving unnecessary psychotropic medications and experiencing adverse consequences related to their use. Findings include:	F 329	B) Resident #7 was evaluated by Vickie Weathers CNS on 5-13-13 for a GDR. C) Resident #10 will not have pain meds and anti-anxiety meds administered at the same time. Non-pharmacological interventions will be attempted and evaluated prior to administering PRN meds. D) Resident #1 expired. E) Resident #2 will have non-pharmacological interventions documented. 2. Any resident receiving a PRN Psychotropic medication has the potential to be affected. 3. A) Educational memo was put on the Medication Administration Record 4-25-13 to alert Charge Nurses of the procedure to implement documentation of non-pharmacological interventions. B) The Unnecessary Medication procedure was reviewed with the Charge Nurses at the All Staff Meeting on May 8th, 2013. C) The DON and Vickie Weathers CNS, discussed the F-329 tag. Copies of the facility's procedure for Unnecessary Drugs were given to Vickie Weathers CNS. She reviewed the documentation needed for	

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 _____	04/18/2013

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 329	Continued From page 34 Review of the facility policy titled "Psychopharmacological Medications and Sedative/Hypnotics" occurred on 04/18/13. This policy, dated January 2009, stated, ". . . Prior to administration of non-emergency psychopharmacological and/or sedative/hypnotics, the following must be completed: . . . Documentation in the medical record of observations of mood symptoms or behaviors that cause the resident distress and/or endangers the resident or others and response to interventions used. . . . ensure the Care Plan is updated. This update will reflect non-pharmacological interventions to be used. . . . Gradual Dose Reductions: The purpose of tapering medication is to find an optimal dose or to determine if continued use of the medication is benefiting the resident. . . . During the first year in which a resident is admitted on a psychopharmacological medication, or after the center has initiated such medication, the center should attempt to taper the medication during at least two separate quarters . . . After the first year, a tapering should be attempted annually unless clinically contraindicated. . . ." Wolters & Kluwer, "Nursing 2013 Drug Handbook," 33rd edition, Lippincott Williams & Wilkins, Pennsylvania, page 844, states regarding Ativan [antianxiety medication], ". . . Adverse Reactions: . . . drowsiness, sedation, . . . insomnia, agitation, dizziness, weakness, unsteadiness, . . . depression . . . " - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included anxiety, rheumatoid arthritis, and left distal femur fracture. The Resident Care Area	F 329	attempted GDR, or when a GDR is clinically contraindicated. 4. A) The Charge Nurses will be responsible to attempt and document non-pharmacological interventions prior to PRN psychotropic medication use. B) Vickie Weathers CNS will be responsible to order GDR, or document when clinically contraindicated. DON and or designee will audit monthly x 3, quarterly x 3, then PRN. Results will be immediately reported to DON. If concerns are identified, corrective action will be implemented. A report will be submitted to the QA Committee at each scheduled meeting. 5. Date to be in compliance	5/28/13

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 _____	04/18/2013

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 329	Continued From page 35 Assessments (CAAs), dated 03/18/13, identified the following: * Behavioral Symptoms: ". . . She has had acute pain to her left knee which has distressed her and may have impacted her mood and anxiety level as well. . . . [Resident #1] does does [sic] have [a] history of yelling out loudly, sometimes repeatedly. The yelling does not always seem to signify need . . ." * Psychotropic Drug Use: ". . . [Resident #1] does also take Ativan [anxiety medication] 0.5mg [milligrams] . . . daily d/t [due to] increased agitation. She does have a[n] Ativan 0.5mg prn [as needed] does [sic] . . . for increased yelling/agitation/restlessness. Note that this medication does not always give her relief. . . ." * Pain: ". . . [Resident #1] did present with pain to her left knee . . . She has subsequently been identified as having a left femur fracture. . . . [Resident #1] does continue to take previous order for Tylenol 650mg tid [three times daily]. . . ." The current comprehensive care plan identified, ". . . Problem: Alteration in comfort r/t [related to] fx [fracture] to left femur . . . Approaches: Medicate as ordered . . . Offer non-medicine interventions for pain relief: position change . . ." Although Resident #1's care plan identified, ". . . Problem: . . . frequent calling out which creates disturbances for other residents," the facility failed to identify non-pharmacological interventions staff should attempt prior to administering Ativan. The Medication Administration Record (MAR) identified the following: * Tylenol 650 mg BID [twice daily] PRN (Ordered 03/02/12)	F 329		

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 _____	04/18/2013

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 329	Continued From page 36 * Ativan 0.5 mg every 6 hrs PRN for anxiety/insomnia (Ordered 03/15/12) * Vicoprofen 1 tab every 4-6 hours PRN for severe pain (Ordered 02/04/13 - Discontinued 02/18/13) The PRN medication notes, dated January 26 - April 1, 2013 identified staff administered: * Ativan 33 times for anxiousness, agitation, restlessness, moaning, calling/yelling out, hollering, and/or screaming. Facility staff failed to atempt non-pharmacological interventions attempted prior to administering the Ativan on all 33 occasions. * Ativan and Tylenol at the same time on five occasions: 01/26/13 at 7:00 a.m., 01/30/13 at 11:00 a.m., 02/04/13 at 6:15 a.m., 03/10/13 at 7:00 a.m., and 03/13/13 at 6:00 a.m. * Ativan and Vicoprofen at the same time on two occasions: 02/08/13 at 05:30 a.m. and 02/14/13 at 11:00 p.m. Failure to attempt non-pharmacological interventions and monitor the effectiveness of those interventions prior to administering an anti-anxiety medication does not allow staff to evaluate what interventions are most effective for the behavior. Facility staff administered anti-anxiety and pain medications simultaneously, and subsequently failed to assess the effectiveness of each medication individually, which may have resulted in Resdient #1 receiving unnecessary medications. See F309. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses	F 329		

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 _____	04/18/2013

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 329	Continued From page 37 included dementia, cerebrum malignancy, mental disorder, and psychosis. The current comprehensive care plan identified, ". . . Problem: Potential for verbal and physical agression [sic] . . . Approaches: . . . Escort [Resident #2] to an environment that reduces agitation and provides a sense of safety and security . . . Listen and provide support when [Resident #2] expresses thoughts and feelings . . . Monitor [Resident #2's] wandering. Redirect [Resident #2] to supervised areas if found in other resident's room or wandering in halls. . . . Encourage [Resident #2] to stay in dinning [sic] area thru [through] out meals . . . Escort and encourage [Resident #2] to participate in evening activities or engage in independent activities in common area . . . Offer activities from TV cabinet or activity bin . . . Problem: Altered thought process . . . Approaches: . . . Offer [Resident #2] opportunities for decision-making . . . Offer 1:1 activities in common areas . . . Provide opportunities for [Resident #2] to participate in therapeutic work on a voluntary basis . . . Redirect [Resident #2] as indicated when exhibiting sexual inappropriateness. . . . " The MAR identified the following: * Seroquel 150 mg TID prn used to treat agitation/aggression (Ordered 03/18/13 - Increased from 50 mg BID prn 10/15/12) The PRN medication notes, dated December 2, 2012 - April 12, 2013 identified staff administered: * Seroquel 50 mg 33 times for increased agitation, aggression, combativeness, restlessness, hitting/striking out and/or pacing/wandering. Facility staff failed to identify	F 329		

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 _____	04/18/2013

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 329	Continued From page 38 non-pharmacological interventions attempted prior to administering Seroquel on 20 of 33 occasions. * Seroquel 150 mg seven times for increased agitation, combativeness, restlessness, and grinding his teeth. Facility staff failed to identify non-pharmacological interventions attempted prior to administering Seroquel on six of the seven occasions. Failure to attempt non-pharmacological interventions and monitor the effectiveness of those interventions prior to administering an anti-psychotic medication does not allow staff to evaluate what interventions are most effective for the behavior and may have resulted in Resident #2 receiving unnecessary medications. - Review of Resident #10's medical record occurred on April 17-18, 2013. Diagnoses included depressive disorder, dementia, and dementia - Alzheimer's type without behaviors. Review of Resident #10's plan of care, dated 12/20/12, stated, "Problems/Needs/Concerns: Altered thought process R/T [Related To] dementia, depressive disorder, history of UTI's [urinary tract infections] M/B [manifested by] confusion/anxiety . . . Plans and Approaches: Provide redirection: music, reminiscing, T.V. [television] sports, game shows. Encourage relaxation: resting in recliner reduce over stimulation & stress . . . Confusion: reassure, TLC [tender loving care] reorientate to person, place. Monitor/Report depressive mood refer to mental health consultant as needed." Review of Resident #10's physician orders	F 329		

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 _____	04/18/2013

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 329	Continued From page 39 identified the following medication orders: * 03/29/13: Ativan 0.25 mg BID PRN for agitation * 12/07/12: Acetaminophen (Tylenol) 650 mg every four hours prn The PRN medication notes, dated March 29 - April 17, 2013, identified staff administered: * Ativan 14 times for increased agitation, increased anxiety, crying, restlessness, and/or aggressiveness. Staff failed to identify the "specific" behavior displayed prior to administering Ativan on 13 occasions and failed to identify non-pharmacological interventions attempted prior to administering Ativan on all 14 occasions. * Ativan and Tylenol at the same time on seven occasions: March 29, April 3, 6, 9, 13 (twice), and 17. Failure to identify the specific behavior exhibited, attempt non-pharmacological interventions related to Resident #10's behavior, and monitor the effectiveness of those interventions prior to administering an anti-anxiety medication does not allow staff to evaluate causative factors and what interventions are most effective for the behavior. Facility staff administered anti-anxiety and pain medications simultaneously, and subsequently failed to assess the effectiveness of each medication individually, which may have result in Resdient #10 receiving unnecessary medications. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Down's syndrome, dementia, probable Parkinson's disease, seizure disorder, and psychotic disorder for hallucinations. Current physician orders included 0.5 mg Ativan prn for	F 329		

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 _____	04/18/2013

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 329	Continued From page 40 agitation and anxiety (initiated on 08/18/12). Review of Resident #3's current plan of care, dated 02/21/13, stated the following plans and approaches, ". . . Disruptive crying out . . . Approach with low soft tone of voice and approach from front when speaking to [resident] due to vision impairment, hold hand or give light touch on arm or back . . . Yelling out and crying . . . Provide divertions [sic] as situation warrants removing [resident] from overstimulation situations to quiet area, offering water or favorite pop 7-up, sit with him and hold hand, assure him he is in a safe home and will be taken care of . . . Coping . . . assist [resident] thru grieving process due to loss of mother. Assist with phone calling to his family. Review family pictures in his room. Give 'TLC'. . . . Disruptive behavior . . . schedule mental health appointments . . . Individual coping . . .when [resident] becomes overstimulated in environment evidenced by crying spells and resistants [sic] to cares lead to him [sic] to room and offer diversonal [sic] activities such as listening to country music, watching T.V., looking at family pictures and reading his bible . . . .When found wandering ask if he is thirsty, hungry needs to toilet or wants companionship . . . Wandering . . . assist to a familiar area . . . Observe [resident] in group activities to assess what calms and engages him . . . Offer [resident] supplies and items such as coloring books, crayons, children bibles, children books, chimes, baloons [sic], to deter him from wandering . . . " Review of Resident #3's MAR for December 2012 through March 17, 2013 showed prn Ativan used 21 times for increased increased anxiety with calling out and "weepy," increased	F 329		

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 _____	04/18/2013

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 329	Continued From page 41 anxiety/agitation, and anxiety/crying with "verbal aggression," "resisting cares," and/or not "cooperative" with cares. Facility staff failed to identify non-pharmacological interventions attempted prior to administering Ativan on 16 of the 21 occasions. During an interview on 04/17/13 at 2:10 p.m., an administrative nurse (#13) stated the expectation is for nurses to monitor and document the effectiveness of non-pharmacological interventions prior to administering prn Ativan. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, adjustment disorder with mixed disturbance of emotions, dementia with behavioral disturbance, and depression. Physician orders included Ativan 0.5 mg TID (frequency increased on 09/27/11 from 0.5 mg daily) with 1 mg orally or intramuscularly prn for agitation/behaviors BID. The nurses' notes showed Resident #7 fell three times in the past two months. The annual MDSs, dated 02/22/12 and 01/31/13, and the quarterly MDS, dated 10/31/12, indicated the resident displayed no physical, verbal, or other behaviors. The MDSs showed increasing symptoms of depression, feeling tired or having little energy, and trouble falling/staying asleep or sleeping too much on each subsequent assessment. During interviews on 04/17/13 at 5:00 p.m. with a nurse administrator (#2) and on 04/18/13 at 8:23 a.m. with a pharmacist (#9) regarding a GDR of the Ativan, they could not provide rationale why a GDR was not considered in the last 18 months.	F 329		

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 _____	04/18/2013

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 329	Continued From page 42 Resident #7's record failed to identity a GDR attempt (or a clinical contraindication) of the Ativan since 09/27/11. Failure to address a GDR may prevent Resident #7 from attaining or maintaining the highest practicable level of physical and mental well-being, may contribute to unnecessary medication, and cause adverse consequences related to its use.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the consulting pharmacist failed to identify and report a drug regimen irregularity regarding gradual dose reduction (GDR) to the attending physician and the director of nursing for 1 of 7 sampled residents (Resident #7) receiving antianxiety medications. Failure to suggest a GDR of Ativan has the potential for the resident to receive unnecessary medication and experience adverse consequences related to the medication. Findings include:	F 428	F-428 1. Resident #7 was evaluated for GDR by Vickie Weathers CNS 5-13-13. Bonnie Thom RPH, Consultant Pharmacist, will evaluate all residents 5-17-13. 2. Any resident receiving a Psychotropic med has the potential to be affected. 3. Consulting Pharmacist received education regarding F-428 on 4-18-13. The Pharmacist will review each resident monthly, and report any irregularities.	

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 _____	04/18/2013

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 428	Continued From page 43 Review of the facility policy titled "Psychopharmacological Medications and Sedative/Hypnotics" occurred on 04/18/13. This policy, dated January 2009, stated, ". . . Gradual Dose Reductions: The purpose of tapering medication is to find an optimal dose or to determine if continued use of the medication is benefiting the resident. . . . During the first year in which a resident is admitted on a psychopharmacological medication, or after the center has initiated such medication, the center should attempt to taper the medication during at least two separate quarters . . . After the first year, a tapering should be attempted annually unless clinically contraindicated. . . ." Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, adjustment disorder with mixed disturbance of emotions, and dementia with behavioral disturbance. Physician orders included the antianxiety medication Ativan 0.5 milligrams (mg) three times daily (TID) (increased on 09/27/11 from 0.5 mg daily) with 1 mg orally or intramuscularly as needed (prn) for agitation/behaviors twice daily (BID). The consulting pharmacist's monthly Medication Regimen Review (MRR) from January through December 2012 failed to address Resident #7's continued use of the Ativan. The MRRs for 2013 contained an entry on 02/18/13 stating, ". . . continues Ativan 0.5 mg tid & prn . . . May also need to re-evaluate scheduled Ativan use after completing of Geodon taper/ discontinue. . . ." The pharmacist failed to suggest a GDR or request documentation as to why a GDR was	F 428	4. An audit tool will be developed to ensure the Consulting Pharmacist has identified and attempted a GDR at ~~least 2 separate quarters in the first year of use. After the first year, tapering should be attempted annual~~ly unless clinically contraindicated supported by documentation. The DON will follow up monthly from Pharmacist's written reports, and notify the Medical Practitioners as needed. Reports will be given to the QA Committee at scheduled meetings. according to CMS guidelins JB changed on 5-22-13 per conversation with DON. 5. Date to be in compliance	5/28/13

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 _____	04/18/2013

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 428	Continued From page 44 clinically contraindicated since 09/27/11. Following interviews on 04/17/13 at 5:00 p.m. with a nurse administrator (#2) and on 04/18/13 at 8:23 a.m. with a pharmacist (#9) regarding a GDR of Resident #7's Ativan, neither individual provided evidence that tapering the Ativan was attempted annually or that a GDR was clinically contraindicated.	F 428		
F 494 SS=D	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.	F 494	F-494 1. Two GSS-Mohall Nursing Assistants had their certification re-instated. 2. All licensed or certified employees have the potential to be affected. 3. Staff Development Coordinator will post reminders to employees to keep their licenses and certifications up-to-date, and to notify the Staff Development Department when their license is	

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 _____	04/18/2013

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 494	Continued From page 45 This REQUIREMENT is not met as evidenced by: Based on review of state nurse aide registry files, facility record review, policy review, and staff interview, the facility failed to ensure nurse aides (Individuals A and B) working with residents in the facility remained certified. Individuals A and B provided hours of nursing related services without verifying competency through certification. Failure to ensure certification of caregivers has the potential to affect resident care. Findings include: Review of the facility policy titled "Registry/Licensure Verification" occurred on 04/18/13. This policy stated, "The employee is responsible to renew all documents as required and provide the supervisor with renewals and updates as they occur. . . . Not allowed to work if license is past due . . . Helpful to maintain a list of credentials and experience in the center to ensure no one is practicing with expired documents. . . ." - The employer for Individual A contacted the state nurse aide registry on 09/11/12 to renew the individual's certification. The state nurse aide registry file review identified Individual A's certification expired 04/27/12. Fax transmissions from the facility verified Individual A worked 56.25 hours (7 shifts) with an expired certificate. - The employer for Individual B contacted the state nurse aide registry on 04/18/13 to renew the individual's certification. The state nurse aide registry file review identified Individual B's certification expired 02/15/13. Fax transmissions	F 494	renewed so that it can be entered into the Learning Center System. 4. CNA Instructor will audit monthly x 3, then quarterly. 5. Date to be in compliance	5/13/13

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 _____	04/18/2013

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 494	Continued From page 46 from the facility verified Individual B worked 275.5 hours (35 shifts) with an expired certificate. During an interview on 04/18/13 at 10:40 a.m., a staff development nurse (#10) stated the facility tracks employee license and certificate expiration dates on the Good Samaritan Society "License and Certification Report by Employee" program. This nurse stated she checks the report every couple of months and updates expiration dates as she receives a copy of an employee's certificate or license from the office. Review of this report showed the facility failed to update the status of four employees showing lapsed licenses or certificates, which were actually current. The report identified one employee (Individual B) with a nurse aide certificate expiration date of 02/14/13.	F 494		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514	F-514 1. Progress Notes for Resident #1 were obtained for State Survey Review on 4-18-13. 2. All residents seen by Medical Providers have the potential to be affected. 3. A) Progress (clinic) notes will automatically be sent over either via fax or manually printed and delivered for all residents seen either at the Trinity-Community Clinic Mohall, or for rounds at GSS-Mohall with either Dicky Paige PA, or Ruth Stanley FNP-C.	

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 _____	04/18/2013

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 514	Continued From page 47 Based on record review and staff interview, the facility failed to maintain medical records in accordance with accepted professional standards and practices for 1 of 1 sampled resident (Resident #1) whose record failed to contain "Clinic Notes." Failure to ensure medical records are complete and/or readily accessible limits the facility and/or physician's ability to ensure the provision of appropriate care and services. Findings include: - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included anxiety, rheumatoid arthritis, and left knee supracondylar femoral fracture. The interdisciplinary progress notes identified the following: * 01/27/13 at 2:00 p.m., identified, ". . . Examined noting (L) [Left] knee [increased] warmth, swelling, [and] redness. [Resident #1] does not want to bear weight on this leg. Will monitor [and] send to clinic tomorrow. . . ." * 01/28/13 at 1:25 p.m., "Left in w/c [wheelchair] for Clinic . . ." (Seen by Family Nurse Practitioner-FNP) * 02/04/13 at 2:30 p.m., "Cont [Continues] to hollor [sic] this am . . . to CNA nodded head yes to gen. [general] ache all over. . . . Taken to clinic in w/c by staff . . . L Leg swollen to knee [above] [and] [below] . . ." * 02/18/13 at 11:50 a.m., "[FNP] from Clinic came to see [Resident #1] . . . L knee swollen, sl [slightly] warm to touch . . . Screams when Rt [Right] leg moved so could see L knee better. Also - sweaty at this time but [no] temp [temperature]. . . ."	F 514	B) Progress notes for residents seen on monthly rounds at GSS-Mohall by Dr. Pugatch, Medical Director will be sent to GSS-Mohall HIM Director by Trinity Release of Information via fax after dictation and transcription has occurred. 4. Trinity Release of Information will be contacted by the HIM Director two weeks after the date of the Medical Director's monthly rounds if the progress notes have not yet been received. The HIM Director will then add an IDP note to the chart of each resident that was seen on the date of rounds indicating the status of the Progress Note. This every 2 week auditing process will continue indefinitely until the progress notes for each resident has been completed and received. As each Progress Note is received it will be date stamped by the HIM Director to indicate which date they arrived. 5. Date to be in compliance	5/28/13

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 _____	04/18/2013

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 514	Continued From page 48 Upon request on 04/18/13, the facility obtained copies of the "Clinic Notes" dated 01/28/13, 02/04/13, and 02/18/13. During an interview on 04/17/13 at 3:30 p.m. and at 4:50 p.m., two administrative staff members (#2 and #6) stated, "They [Clinic Notes] are not automatically sent." They confirmed the facility failed to obtain copies of Resident #1's notes. Failure to have the clinic notes readily accessible potentially limited the physician's ability to ensure appropriate care and services. See F309.	F 514		