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 _____	04/07/2021

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

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 04/05/21 and concluded on 04/07/21.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: MEDICATION ADMINISTRATION: 1. Based on observation, record review, policy review, and staff interview, the facility failed to administer medications in a manner to ensure efficacy for 1 of 1 resident (Resident #5) observed during med pass. Failure to administer Depakote (indicated for seizure disorder) intact versus crushed has the potential to affect the medication absorption rate and efficacy. Findings include: Review of the facility policy titled "Medications: Crushing" occurred on 04/07/21. This policy, revised on December 2020, stated, ". . . Some medications, such as sustained release medications among others, are not to be crushed or chewed. . . ." Review of facility's list of medications that should not be crushed included the medication Depakote tablet Delayed Release.	F 658	F658 Services Provided Meet Professional Standards. Medication Administration 1. Resident #5 will not have Depakote crushed but will be given whole in pudding. Her Depakote card has been labeled and staff made aware. 2. All residents with crushed medication orders have the potential to be affected. Consultant pharmacist will review all crushed medications on April 26th rounds. 3. A) All Nurses and Medication Aides will be in-serviced regarding the crushed medication procedure during one of the Staff In-services April 20-23st by the DON. B) The Pharmacist will review all residents with Crushed medication orders for Sustained Release or Delayed release medication risk and review with the DON. If residents are unable to swallow the pill without crushing the medication, the Medical Practitioner will be notified for	5/12/21

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

Electronically Signed | 04/23/2021

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F 658	Continued From page 1 Review of Resident #5's medical record occurred on all days of survey. The physician's orders included may crush medications if not contraindicated and Depakote tablet Delayed Release 125 mg (milligrams) three tablets by mouth four times a day. Observation on 04/07/21 at 11:44 a.m. showed a medication aide (#2) crushed three Depakote Delayed Release 125 mg tablets, mixed the crushed medication in pudding, and administered it to Resident #5. During an interview on 04/07/21 at 12:49 p.m., a nurse manager (#1) agreed the Depakote medication should not be crushed. PHYSICIAN ORDERS 2. Based on record review, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 6 residents (Resident #16) reviewed for unnecessary medications. Failure to implement physician's orders to complete annual lab tests has the potential to delay changes to the resident's plan of care based on the test results. Findings include: Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 68, stated, ". . . Carrying Out a Physician's Order . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ."	F 658	further orders. White drug has been contacted regarding need to apply a "Do Not Crush" sticker" to all cards that have non-crushable medications. 4. The DON or designee will monitor/audit medication pass weekly for one month, monthly x 3 months, quarterly, and PRN. Results will be reported to the Director of Nursing. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting and will follow recommendations of the QAPI committee related to frequency and compliance. Physician Orders 1. Resident #16 will have annual labs completed timely in September 2021. 2. All residents with Annual labs have the potential to be affected. 3. All residents with Annual labs will be have their chart reviewed for completion of their Annual labs in the last year by the first of May. 4. Nursing management and charge nurses will be in serviced April 20-23 on process for inputting lab, and following through with lab. The Lab Nurse and Health Information Manager will develop an audit to ensure all lab orders are drawn as ordered and lab results uploaded in to the EHR in a timely manner. The audit will be done monthly x 3, then quarterly, and PRN. Results will be reported to the Director of Nursing and	

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F 658	Continued From page 2 Review of Resident #16's medical record occurred on all days of survey. Diagnoses included type 2 diabetes mellitus and hypothyroidism. Medications included Levemir (long-acting insulin), NovoLog (short-acting insulin), and glimepiride (oral diabetes medication). A physician order, dated 08/25/15, stated, "CMP [comprehensive metabolic panel], HgbA1c [hemoglobin A1c - monitors how well blood sugar levels are managed], Lipids and TSH [thyroid-stimulating hormone] to be drawn yearly." The pharmacist's Drug Regimen Review, dated 12/31/20, stated, "Resident has orders for yearly labs - her CMP and lipids are current, but she has not had an A1c or TSH drawn since August/September 2019 - labs due." A physician's progress note, dated 02/09/21, stated, ". . . The patient has history of uncontrolled insulin-dependent diabetes, hypothyroidism, . . . She is due for diabetic labs . . . ." The physician orders on this date stated, "Draw Hgb A1c, TSH and Free T." Resident #16's lab results, dated 2/23/21, showed elevated levels for the HgbA1c and TSH. During an interview on 04/07/21 at 4:50 p.m., a nurse manager (#1) agreed the facility missed ordering the labs for Resident #16 in August/September 2020 [over seven months late]. SKIN IMPAIRMENT	F 658	if concerns are identified, immediate corrective action will be implemented. The Lab Nurse and Health Information Manager will submit a report of the monitoring results to the QA Committee at each scheduled meeting and frequency and compliance will be determined by the QAPI committee. Skin Impairment 1. Resident #23 open area to right cheek will be monitored and documentation in weekly Skin Observation UDA weekly till healed. This has ben implemented for her. 2. All residents with Skin impairments have the potential to be affected. 3. A) All residents will have a skin assessment done to assess for skin impairments by 5/3/21. If a skin impairment is found it will be put in the Nursing MAR to follow up weekly, documentation in Skin Observation UDA weekly and care plan to reflect care as appropriate, and notify Medical Practitioner if changes. B) All Charge Nurses and nursing staff will be in-serviced in the Wound policy/procedure and facility wound protocol during one of the Staff In-services April 20-23st by the DON. 4. The DON or designee will be responsible to monitor/audit for Skin impairments and the weekly documentation. Monitoring will be done weekly for one month, monthly for three	

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F 658	Continued From page 3 3. Based on observation, record review, review of facility policy, resident interview and staff interview, the facility failed to follow professional standards of practice for 1 of 3 sampled residents (Resident #23) with skin impairments. Failure to assess, monitor, or document skin impairments may result in worsening signs/symptoms and delayed treatment. Findings include: Review of the facility policy titled "Skin/Wound Communications . . ." occurred on 04/07/21. This policy, dated 12/13/18, stated, ". . . Excoriations/Dermatitis/skin tears/bruises/ etc. A. Need to be documented in a 'Health progress note' weekly by the Charge nurses. Put in the Nursing tab so it gets done and shows up to cue you!!" Observation on 04/05/21 at 11:40 a.m. showed an open area to Resident #23's right cheek. The resident stated the area to her cheek has been there for "about a month" and "opened and started to bleed when they [facility staff] washed my face." Review of the medical provider's 60 day med (medication) review, dated 03/03/21, stated, ". . . Newly developed right cheek area hyperkeratotic [thickening of the skin] horn [protrusion]. Plan: . . . Did discuss with patient about the removal of the keratotic horn at this point she is not concerned about it and [sic] let us know if we need to remove this. Follow-up per nursing home protocol and as needed for concerns patient verbalized . . ."	F 658	months, and then quarterly and PRN. Results will be reported to the Director of Nursing. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting and frequency and compliance will be determined by QAPI committee.	

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F 658	Continued From page 4 Review of Resident #23's medical record lacked evidence of nursing assessment, monitoring, or documentation of the right cheek open area. During an interview on 04/07/21 at 11:59 a.m. administrative staff (#1 and #6) agreed nursing staff should have identified, assessed, and initiated the facilities protocol for Resident #23's right cheek impairment.	F 658		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 756		5/12/21

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F 756	Continued From page 5 irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to ensure the attending physician and/or Director of Nursing (DON) reviewed and acted on the consultant pharmacist's recommendations for 2 of 6 residents (Resident #16 and #24) reviewed for unnecessary medications. Failure of the physician or DON to review and act on the drug irregularities identified by the consultant pharmacist in a timely manner may result in the prolonged, ineffective, or unnecessary use of medications and may result in adverse consequences. Findings include: Review of a facility policy titled "Medication - Drug Regimen Review" occurred on 04/07/21. This policy, dated 12/11/20, stated, ". . . Monthly Drug Regimen Review . . . The pharmacist will complete a written report noting any drug irregularities or issues of concern for each resident reviewed. The pharmacist will also	F 756	1. Resident #16 lab work was obtained and reviewed prior to survey. Resident #24 insulin had been adjusted prior to survey. 2. All residents have the potential to be affected by this tag. All March 29th reviews will be faxed and reviewed by the MD/NP. The past 6 months of recommendations have been uploaded into the Electronic Record under the heading of Pharmacy consultant report. The current pharmacist will perform medication review on 4/26/2021 and then White Drug Consultant pharmacist will begin services with first review being 1st or 2nd week of May, this will allow for two thorough reviews in short time span to ensure complete and accurate review. This will be an ongoing change. 3. The facility will follow the GSS process/procedure ensuring that proper follow up occurs in allotted period of time per policy and pharmacist	

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F 756	Continued From page 6 complete the Medication Regimen Review Summary for QAPI [Quality Assurance and Performance Improvement] Committee . . . Both reports will be given to the director of nursing services upon completion of each monthly DRR [drug regimen review]. The reports must be shared with the attending physician and the location's [facility's] medical director, and these reports must be acted upon. . . . Drug irregularities will be reported to the medical director and attending physician by the director of nursing services or designee. The location must designate someone to ensure that these reports have been acted upon within 30 calendar days of the review and have been documented. . . ." - Review of Resident #16's medical record occurred on all days of survey. Diagnoses included type 2 diabetes mellitus and hypothyroidism. The pharmacist's Drug Regimen Review summary report, dated 04/29/20, stated, "Resident's [#16] blood sugars elevated ranging 180 to > [greater than] 300 on levemir [long-acting insulin] 28u [units] twice daily and Novolog [short-acting insulin] 5u with meals plus sliding scale. Dose last increased in Feburary (sic) [2020] for both regimens. Recommend further increase of insulin dose to get blood sugars < [less than] 300." The pharmacist recommended the same action on his/her Drug Regimen Review summary, dated 6/16/20. A physician progress note, dated 06/16/20, stated to increase Levemir to 30 units twice daily and increase Novolog to 7 units with meals. Resident #16's record lacked evidence of an	F 756	recommendation. All recommendations will be printed and given to Nurse manager for follow up on next rounds, or faxed to provider if waiting for next rounds is beyond the 30 days. Copies will be made and placed in the Pharmacy book. Once the original is reviewed by MD and proper follow up occurs the original will be given to DON to review and verify. Once DON has approved and verified order changes have been carried out, the original will be given to medical records for uploading. Once uploaded the original form will be returned to pharmacy book for the Consult Pharmacist to review MD recommendations during the next review. Medical director will review at quarterly QAPI meetings. 4. Administrator or designee will audit 100% of pharmacy recommendations for 3 months, and then quarterly until determined by QAPI that compliance is sustained. Education will occur with DON, and nurse managers 4/19/2021 and training completed by LNHA.	

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F 756	Continued From page 7	F 756		

individual report of the irregularities on the two summary reports listed above or action taken following the pharmacist's 04/29/20 recommendation. The physician failed to act upon the recommendations until 48 days later, when the pharmacist repeated the recommendations on 06/16/20.

The pharmacist's Drug Regimen Review summary, dated 12/31/20, stated, "Resident has orders for yearly labs - her CMP [comprehensive metabolic panel] and lipids are current, but she has not had an A1c [hemoglobin A1c] or TSH [thyroid-stimulating hormone] drawn since August/September 2019 - labs due."

Resident #16's record lacked evidence the DON or designee provided this recommendation to the physician or the physician acted upon the recommendation in a timely manner until 40 days later during a physician visit on 02/09/21. Refer to F658.

- Review of Resident #24's medical record occurred on all days of survey. Diagnoses included type 2 diabetes mellitus and dementia.

The pharmacist's Drug Regimen Review summary report, dated 12/21/20, stated, "Resident's Lantus [Long-acting insulin] dose was doubled while in the hospital in November to 10 units daily. Since increase, resident is having frequent hypoglycemia, as low as the 60s. Recommend decrease dose to 8 units daily to maintain fasting BG (blood glucose) > (greater than) 100.

A physician progress note, dated, 01/12/21,

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F 756	Continued From page 8	F 756		

stated," . . . Continue Lantus 5 units daily for DMII." The facility failed to verify with the physician the correct dosage of Lantus insulin.

The pharmacist's Drug Regimen Review summary report, dated 02/29/21, stated, "Per [Doctor's name] provider note from 01/12/21, he stated residents blood sugar is stable on Lantus 5 units daily. Her current dose is 10 units daily since 11/02/20 and she is having frequent hypoglycemia (low blood sugars) <100, into the 50s and 60s. Please have provider update medical chart for resident. I also recommend that provider considers reducing resident's dose of Lantus to 5 units daily as she is cognitively impaired and having frequent hypoglycemia. Per ADA guidelines, it is recommended that fasting blood sugars should be maintained > 100 for resident safety."

Physician order, dated 03/26/21, stated, "Lantus SoloStar Solution Pen-injector 100unit/ML (Insulin Glargine) Inject 5 units subcutaneously one time a day."

Resident #24's record lacked evidence the DON or designee provided the 12/21/20 recommendation to the physician or the physician acted upon the recommendation in a timely manner. The pharmacist repeated the recommendation on 02/29/21. The facility failed to act on the initial recommendation causing the order to be put in place 98 days later, on 03/26/21.

During an interview on 04/07/21 at 5:17p.m., an administrative staff member (#3) stated the facility's Drug Regimen Review process is an

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F 756	Continued From page 9 issue they need to work on.	F 756		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, the facility failed to provide food service in a sanitary manner on 2 of 3 days of survey (April 5 and April 7, 2021). Failure to perform hand hygiene while distributing food to residents during meal service and failure of staff to wear an apron while preparing dirty dishware for washing may result in forborne illness to residents, staff, and visitors. Findings include:	F 812	Plan of Correction for F812. Ware Washing 1. No residents were directly affected by F tag 812. 2. All residents could be potentially affected by Ftag 812. 3. Staff educated at all staff, and dietary meeting will be held on April 30, 2021. Staff Education on Apron wearing in the kitchen was done on April 8, 2021 and ongoing. Policy and procedure has been discussed. Education specific to	5/12/21

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F 812	Continued From page 10 HAND HYGIENE Review of the facility policy titled Hand Hygiene and Handwashing-Rehab/Skilled, Senior Living, occured on 04/07/2021, dated, 04/06/2021 stated: "To ensure appropriate hand hygiene technique for clinical use. Patient care: The goal to prevent the spread of infection between residents. Food service . . . never touching their food with bare hands. . . During service of meals: Wash hands before meal service begins. . . whenever contaminated by touching a resident, self or any surface. Do not touch any food or eating surfaces with bare hands. . . drinking surface of glasses." During a dietary observation on 04/05/21 at 11:45 a.m., a dietary aide (#5) failed to perform hand hygiene after touching resident's silverwear, the dining room fridge handle, a carton of juice and the kitchen door, between individual tray deliveries. Observation showed the dietary aide (#5) delivered beverages holding a glass by the rim. Interview on 04/07/2021 at 1:00 p.m., the dietary manager (#4) agreed facility staff failed to perform correct hand hygiene while distributing residents food trays. Her expectation is for staff to follow he facility hand hygiene policy. WARE WASHING Review of the facility policy titled, Employee hygiene and dress code-Food and Nutrition Services, dated 07/09/2020 stated, "The hygiene and dress code policy are enforced. Aprons are provided and laundered by the location.	F 812	department will be done by UM. 4. QA. Audits will be done, by CDM or designee, on appropriate apron wearing 3x a week for 1 months, then 2x a week for 2 months, 1x a week for 2 months, then quarterly, if in compliance, as per QAPI recommendation. 5. The date of correction will be done by May 12, 2021 Hand Hygiene 1. No Residents were directly affected by the hand hygiene portion of Ftag 812. 2. All residents could potentially affected by hand hygiene portion of Ftag 812. 3. Staff educated at the all staff in-service, and dietary meeting will be held April 30, 2021. Moments of hand hygiene, and a hand washing audit will be done for all kitchen staff. Education will be completed by CDM. 4. QA audits will be done by the CDM or designee, 3x a week for one month, 2x a week for 2 months, 1x a week for 2 months, once monthly for a quarter, then quarterly, as per QAPI recommendation.	

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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 812	Continued From page 11 Disposable aprons may be used. Employees put on clean apron at beginning of shift. . . change as necessary . . . to prevent contamination and ensure cleanliness. Employees change aprons between "dirty and clean sides," while washing dishes." During observations of staff performing ware washing on 04/05/21 at 12:40 p.m., and 04/07/21 at 12:30 p.m., dishwashing staff failed to wear a protective apron while handling dirty dishes. Staff placed dirty dishes on a dishwashing rack, put the rack into the dishwasher and turned on the dishwasher. Without performing hand hygiene, the staff moved to the clean dishes, removed them from the racks and put them away. Dishwashing staff failed to wear an apron when working with dirty dishes, and failed to perform hand hygiene when moving between dirty and clean dishes. During an interview on 4/07/21 at 1:00 p.m., the dietary manager (#4) confirmed staff should wear aprons and perform hand hygiene when washing dirty dishes and staff are to perform hand hygiene between dirty and clean dishes.	F 812		