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 _____	05/22/2019

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 The standard Medicare/Medicaid recertification survey started on 05/19/19 and concluded 05/22/19.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		6/26/19

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

Electronically Signed | 06/16/2019

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 _____	05/22/2019

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 578	Continued From page 1 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to ensure the resident's right to request, refuse, and/or discontinue treatment for 4 of 13 sampled residents (Resident #20, #38, #48, and #252) and 1 supplemental resident (Resident #47) reviewed for advance directives. Failure to ensure all methods of communication and/or documentation of code status for each resident accurately reflected the resident's wishes has the potential to limit his/her access to life-sustaining services or result in unwanted treatment. Findings include: Review of the facility policy titled "Advance Care Planning and Advance Directives" occurred on 05/22/19. This policy, dated April 2016, stated, ". . . Policy: Residents and resident surrogate or proxy decision-makers have the right to make decisions concerning medical care, including the right to accept or to refuse medical or surgical treatment. Residents have the right to formulate advance directives. . . . Procedure: . . . 9. Once the staff member has determined the wishes of the resident/healthcare decision-maker, the physician will be notified of the resident's wishes and asked to give orders. . . . 11. Each day the	F 578	1. A. For resident #20 full code status was added to nurse□s sheet on 5/31/19. B. For resident #38 full code was taken off of nurse□s sheet to indicate DNR, no red heart was on resident□s door on 5/31/19. C. For resident # 47 a heart was added to resident□s door and full code was added to the nurse□s sheet on 5/31/19. D. For resident #48 an order for full code (CPR) was added along with full code status to the nurse□s sheet and a red heart by her door on 6/14/19. E. For resident #252 an order for full code (CPR) was added along with full code status to the nurse□s sheet and a red heart by her door on 6/14/19. 2. All residents have a potential to be affected by this deficient practice. 3. DNS went through all resident code statuses and verified all areas of reference for accuracy between 5/31/19 and 6/14/19. Added to the procedure for advance directives that if nothing has been decided nurses will get an order for full code (CPR). Revising current procedure to have DNS or DSS to print the advance directives report weekly and	

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 _____	05/22/2019

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 578	Continued From page 2 nursing staff will print a report of all advance directive orders and keep in a three-ring binder easily accessible to nursing staff. . . . 17. If cardiac arrest occurs, CPR [cardiopulmonary resuscitation] will be initiated unless: a. a valid DNR [do not resuscitate] order is in place . . ." Observation on the afternoon of 5/20/19 showed a report sheet on a clipboard at a nurse's station with information about the residents, including "Full Code [resuscitate]" written by some of the names. During an interview on 5/20/19 at 4:30 p.m., a nurse (#2) stated they used the report to identify the residents' code status, with residents who requested resuscitation listed as "Full Code." She stated if the report lacked "full code" next to a resident's name, then the resident's code status was DNR. The nurse (#2) also stated staff placed a red heart sticker on residents' doors by the residents' names who are full code status. - Review of Resident #20's medical record occurred on May 20-22, 2019. A physician's order, dated 11/26/14, stated, "ADVANCE DIRECTIVE: Resuscitate (CPR)." The nursing report sheet showed nothing written after Resident #20's name, indicating "do not resuscitate." Observation on the afternoon of 05/20/19 showed Resident #20's door included a red heart sticker [resuscitate]. The facility failed to update the report sheet with accurate information related to Resident #20's code status, contradicting her request for resuscitation should her heartbeat or breathing stop.	F 578	verify with nursing sheet & heart stickers. 4. The DNS and designated nursing staff will audit advance directives and quick reference areas weekly x 4, then monthly x 3 and Quarterly x 2, and PRN starting 6/24/19. DNS will report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, who will review and look at trends to make recommendation as needed. If concerns are identified, immediate corrective action will be implemented. The QAPI will use the Model for Improvement for any opportunities for improvement identified. 5. Will be in compliance on 6/26/19.	

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 _____	05/22/2019

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 578	Continued From page 3 During an interview on 05/22/19 at 8:57 a.m., an administrative nurse (#1) stated the nursing report sheet should match the "full code" order for Resident #20, but was unaware who was responsible to update the report sheet. - Review of Resident #38's medical record occurred on May 19-22, 2019. A physician's order, dated 11/15/18, stated, "ADVANCE DIRECTIVE: Do Not Resuscitate (DNR), Intubation OK." The nursing report sheet stated "full code." Observation on the afternoon of 05/20/19 showed Resident #38's door included a red heart sticker [resuscitate], which conflicted with the physician's order. The facility failed to update the report sheet with accurate information related to Resident #38's code status, contradicting the physician's order for no resuscitation. - Review of Resident #47's medical record occurred on May 19-20, 2019. The record identified the facility admitted the resident in November 2018. A physician's order stated, "ADVANCE DIRECTIVE: Resuscitate (CPR)." The nursing report sheet showed nothing written after Resident #47's name indicating "do not resuscitate." Observation on the morning of 05/20/19 showed Resident #47's door lacked a red heart sticker. The facility failed to place a heart sticker on Resident #47's door and update the report sheet with accurate information related to his code status, contradicting his request for resuscitation should his heartbeat or breathing stop.	F 578		

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 _____	05/22/2019

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 578	Continued From page 4	F 578		

- Review of Resident #48's medical record occurred on May 19-22, 2019. The record identified the facility admitted the resident in December 2018. The record lacked evidence of an advance directive or a physician's order for code status. Observation on the afternoon of 05/20/19 showed Resident #48's door lacked a red heart sticker. The nursing report sheet listed nothing by Resident #48's name indicating "do not resuscitate."

During an interview on 05/20/19 at 4:58 p.m., an administrative staff member (#3) stated, "[Resident #48] has no formal paperwork, so she is a 'full code.'"

The facility failed to accurately complete the nursing report sheet with "full code" and place a heart sticker on Resident #48's door consistent with a lack of an advance directive.

- Review of Resident #252's medical record occurred on May 19-22, 2019. The record identified the facility admitted the resident in May 2019. The record lacked evidence of an advance directive or a physician's order for code status. Observation on the afternoon of 05/20/19 showed Resident #252's door lacked a red heart sticker. The nursing report sheet listed nothing by Resident #252's name indicating "do not resuscitate."

During an interview on the morning of 05/21/19, an administrative staff member (#3) stated per Resident #252's admission paperwork and physician's note, the resident and his family were still discussing code status, therefore per policy Resident #252 is a full code until a determination

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 _____	05/22/2019

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 578	Continued From page 5 is made. The facility failed to accurately complete the nursing report sheet with "full code" or place a heart sticker on Resident #252's door until he and his family reached a decision regarding resuscitation. During an interview on 05/21/19 at 4:23 p.m. regarding code status discrepancies, an administrative nurse (#1) stated the nursing report sheet and the heart stickers are used as a quick reference and agreed resuscitation information needs to be correct and consistent in all areas.	F 578		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/07/18 Based on record review, staff interview, review of the facility policy, and review of the Long-Term	F 637	F637 Comprehensive Assessment after Significant Change 1) For Resident #46 a Significant Change in Status Assessment (SCSA) was done with ARD 6/17/19 due to newly	6/26/19

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 _____	05/22/2019

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 637	Continued From page 6 Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 1 sampled resident (Resident #46) who experienced a significant change in status. Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status and identify and implement appropriate interventions. Findings include: Review of facility policy titled "MDS 3.0 (Minimum Data Set)/RAI (Resident Assessment Instrument) occurred on 05/30/19. This policy, revised on April 2019, stated, ". . . PURPOSE: To complete the Resident Assessment Instrument (RAI) within the federally mandated timeline . . . PROCEDURE: SIGNIFICANT CHANGE MDS 1. When a significant change is identified, the professional employee identifying the change will notify the social worker, RN [registered nurse] coordinator or designated employee so that a timeline may be established and communicated to team members. 2. The team member who identified the change . . . will identify whether the change is an improvement or a decline and in what areas . . . NOTE: For information on how to identify a significant change and timelines for completion, see the RAI MANUAL. . . ." The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.16), dated October 2018, page 2-22 stated, ". . . A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff . . . 2. Impacts more	F 637	being coded as Extensive assistance, or Activity did not occur since the last assessment.. 2) All residents that are newly coded as Extensive assistance, Total dependence, or Activity did not occur since the last assessment have the potential to be affected. 3) A. The Long Term Care Facility Resident Assessment Instrument (RAI) User□s manual page 2-22 to 2-28 Significant Change (SCSA) will be reviewed by the MDS Coordinators by 6/21/19. B. The Charge Nurses and Certified nursing assistants will be in-serviced b/w 6/19/19-6/24/19 on what triggers a Sig Change so they can communicate the change to the MDS coordinator or designee, so a 14 day determination period may be established and communicated to team members. 4) A. The MDS Coordinators and Social Service Designee will develop an audit to monitor for possible SCSA weekly x 4, then monthly x 3 and Quarterly x 2, and PRN. B. The MDS Coordinators will submit audit reports starting 6/25/19 to the DNS, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, who will review and look at trends to make recommendation as needed. If concerns are identified, immediate corrective action will be implemented. The QAPI will use the	

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 _____	05/22/2019

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 637	Continued From page 7 than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-25 stated, "A SCSA is appropriate if there are 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., [for example] two areas of ADL [Activities of Daily Living] decline or improvement. . . . Any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since the last assessment . . ." Observation on all days of survey showed Resident #46 as non-ambulatory, in a wheelchair and dependent on facility staff for mobility. Review of Resident #46's medical record occurred on all days of survey. A 5-day Medicare/quarterly MDS, dated 02/04/19, identified the following levels for Resident #46's functional status: walking in room-limited assistance of two staff; walking in corridor-limited assistance of two staff; locomotion on unit-supervision of two staff; locomotion off unit-supervision of two staff. A quarterly MDS, dated 04/26/19, identified the following levels for Resident #46's functional status: walking in room-did not occur; walking in corridor-did not occur; locomotion on unit-extensive assistance of one staff; locomotion off unit-extensive assistance of one staff. A progress note dated 04/29/19 at 10:02 a.m. stated, ". . . he [Resident #46] has had no change	F 637	Model for Improvement for any opportunities for improvement identified. 5) Will be in compliance on 6/26/19.	

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 _____	05/22/2019

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 637	Continued From page 8 in ADL status. . . . is not able to ambulate independently . . ." During an interview on 05/29/19 at 03:53 PM, an administrative nurse (#6) stated she did not think a SCSA was needed. The facility failed to complete a significant change status assessment in response to Resident #46's decline in functional status.	F 637		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 5 of 13 sampled residents (Resident #14, #22, #28, #31, and #46). Failure to accurately complete Section A (Identification Information), Section J (Health Conditions), and Section P (Restraints) of the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION A: IDENTIFICATION INFORMATION	F 641	F641 Accuracy of Assessments 1) A. For Resident #31 a modification was made on 5/23/19 to MDS dated 6/4/19 and section A1500 was corrected to 1 (yes). B. For Resident #22 a modification was made on 6/13/19 to MDS dated 5/26/19 and section A1500 was corrected to 1 (yes). C. For Resident #28 a modification was made on 6/13/19 to MDS with ARD of 3/11/19 to correct J1800 and J1900 to accurately code Fall with major injury. D. For Resident # 14 a modification was made 5/22/19 on quarterly MDS dated 3/01/19 to correct P0100D to 0 (no) other restraint used. E. For Resident #46 a modification was made 6/13/19 on quarterly MDS dated 2/04/19 and MDS dated 4/26/19 in	6/26/19

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 _____	05/22/2019

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 641	Continued From page 9 The Long-Term Care Facility RAI Manual, revised October 2018, page A-19 to A-20, stated, ". . . Section A1500: Preadmission Screening and Resident Review (PASRR) . . . Coding Instructions: Code 0, no: and skip to A1550, Conditions Related to ID/DD Status, if any of the following apply: PASRR Level I screening did not result in a referral for Level II screening, or Level II screening determined that the resident does not have a serious mental illness . . . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID (intellectual disability)/DD (Developmental disability) or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. . . . Coding instructions: Code A, Serious mental illness: if resident has been diagnosed with a serious mental illness: . . . ." - Review of Resident #31's medical record occurred on all days of survey. Diagnoses included psychotic disorder, depression, and anxiety. The PASRR Level I completed on 01/27/16 indicated a level II referral needed. The PASRR Level II findings, dated 01/28/16, stated, "[Resident #31]; meets PASRR Mental Illness inclusion criteria . . ." The significant change MDS, dated 08/15/18, showed staff coded section A1500 "0" (no). - Review of Resident #22's medical record occurred on all days of survey. A PASRR Level I rescreen completed on	F 641	section P0200B to check chair alarm used daily. 2. All residents have the potential for inaccurate coding in sections A (PSSARR), Section J (Falls); Section P (Restraints/Alarms). 3. A) All Resident□s last MDS will have sections A, J, and P checked for accuracy and modified if correction required by the MDS Coordinators. B) The MDS Coordinators will review the RAI User□s Manual coding instructions for sections A, J, and P by 6/21/19. 4. A) The MDS Coordinators will develop an audit to ensure accurate coding on the MDS assessments in A, J, and P weekly x 4, monthly x 3, quarterly x 2 and PRN. B) The MDS Coordinators will submit audit reports starting 6/26/19 to the DNS, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, who will review and look at trends to make recommendation as needed. If concerns are identified, immediate corrective action will be implemented. The QAPI will use the Model for Improvement for any opportunities for improvement identified. 5. Compliance will be on 6/26/19.	

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 _____	05/22/2019

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 641	Continued From page 10 04/21/14 stated, "Resident has a newly reported mental illness diagnosis (schizophrenia) and residential treatment on 4/15/14. Had a psych [psychiatric] eval [evaluation] done on 06/11/13. A status level ii [sic] is required." The Level II completed on 04/28/14, stated, "Resident is eligible to stay in the facility and does not require specialized services." The Annual MDS, dated 05/25/18, showed staff coded section A1500 "0" (no), which resulted in a failure to code section A1510 A, Serious mental illness During an interview on 05/22/19 at 12:07 p.m., an administrative nurse (#4) agreed staff failed to accurately code section A1500 on Resident #22's 05/25/18 MDS. SECTION J: HEALTH CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2018, pages J-30 to J-33 stated, ". . . Any falls since Admission/Entry or Reentry or Prior Assessment, whichever is more recent . . . Coding instructions for J1800: 0 No, skip to K0100 Swallowing Disorder, 1 Yes, continue to J1900 Number of falls. . . ." - Review of Resident #28's medical record occurred on all days of survey. Diagnoses included open reduction of fractured humerus from a fall which occurred on 02/27/19. The significant change MDS, dated 03/11/19, showed staff coded section J1800 "0" (no falls) which resulted in a failure to code section J1900 C, Fall with major injury.	F 641		

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 _____	05/22/2019

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 641	Continued From page 11 SECTION P: RESTRAINTS and ALARMS The Long-Term Care Facility RAI Manual, revised October 2018, page P1, defined physical restraints as "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." Page P8 defined alarms: "An alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident's clothing, motion sensors, door alarms, or elopement/wandering devices." - Review of Resident #14's medical record occurred on May 20-22, 2019. A quarterly MDS, dated 03/01/19, identified P0100D "Other" restraint as "used daily." Resident #14's care plan lacked a problem or interventions related to restraints. Observation throughout the survey failed to show Resident #14 with a restraint in use. During an interview on the morning of 05/21/19, a certified nurse aide (CNA) (#5) stated Resident #14 did not have a restraint that he/she was aware of. During an interview on 05/22/19 at 10:00 a.m., an administrative nurse (#1) confirmed Resident #14 had no restraint and staff failed to accurately code the 03/01/19 MDS.	F 641		

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 _____	05/22/2019

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 641	Continued From page 12 - Review of Resident #46's medical record occurred on all days of survey. A 5-day Medicare/quarterly MDS, dated 02/04/19, and a quarterly MDS, dated 04/26/19, showed section P0200B "Chair Alarm" as blank (not marked). Resident #46's care plan identified an intervention of chair alarms (initiated 02/07/19). Observation throughout the survey showed staff used a chair alarm when Resident #46's sat in his recliner. During an interview on 05/21/19 at 3:50 p.m., an administrative nurse (#6) agreed Resident #46 uses a chair alarm daily and staff failed to accurately code section P0200B "Chair Alarm" on the 02/04/19 and 04/26/19 MDSs.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		6/26/19

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 _____	05/22/2019

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 657	Continued From page 13 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/07/18 Based on observation, record review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the resident's current status for 1 of 13 sampled residents (Resident #46). Failure to review/revise the care plan limited the staff's ability to communicate resident needs and ensure continuity of care. Findings include: Review of Resident #46's medical record occurred on all days of survey and identified the following: - A quarterly Minimum Data Set, dated 04/26/19, showed the resident required extensive assistance of two staff for dressing and extensive assistance of one staff for eating. - The current care plan stated, ". . . DRESSING: Resident requires 1 staff assist, cueing, additional time to perform tasks . . . Provide supervision at meals . . ."	F 657	F657 Care Plan Timing and Revision 1. Resident #46 care plan was revised on 6/14/19 to reflect the current level of assistance required for dressing and eating. 2. All residents have the potential to be affected by this deficient practice. 3. A) The current Comprehensive Care plan Policy and Procedure will be reviewed by the MDS Coordinators and Charge nurses b/w 6/18/19 to 6/21/19. B) Certified nursing assistants will be educated to notify Charge nurses and MDS Coordinators regarding care not matching the Kardex POC information so care plans can be reviewed/revised to accurately to reflect care provided. 4. A) An audit will be developed by the Interdisciplinary team members to ensure residents care plan and Kardex are reviewed/revised to reflect the current level of ADL assistance needed and ensure continuity of care. The audit	

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 _____	05/22/2019

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 657	Continued From page 14 Observation on all days of survey showed Resident #46 required extensive assistance of two staff for dressing and extensive assistance of one staff for eating. During an interview on 05/22/19 at 12:11 p.m., an administrative nurse (#4) agreed the care plan failed to show Resident #46's current dressing and eating status. The care plan failed to accurately reflect the current level of assistance Resident #46 required with dressing and eating.	F 657	will be done weekly x 6, monthly x 3, quarterly x 3, and then PRN. B) The MDS Coordinators will submit audit reports starting 6/25/19 to the DNS, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, who will review and look at trends to make recommendation as needed. If concerns are identified, immediate corrective action will be implemented. The QAPI will use the Model for Improvement for any opportunities for improvement identified. 5. Compliance will be on 6/26/19.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 732		6/26/19

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 _____	05/22/2019

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 732	Continued From page 15 (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure posting of accurate and complete staffing information for 4 of 4 days of survey (May 19-20, 2019). Failure to post accurate staffing data does not allow residents and visitors to be aware of the numbers of licensed and unlicensed staff on duty each shift. Findings include: Observation of the posting of the staffing report occurred on all days of survey. The daily staffing report failed to identify all the categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. During an interview on 05/22/19 at 10:04 a.m., an administrative nurse (#1), agreed the daily printed staffing report failed to identify the required information needed.	F 732	F732 Posted Nurse Staffing Information 1. All staffing sheets were corrected the day of survey exit on 5/22/19 to include RN, LPN, Med aide, and CNA hours. 2. There is no direct harm to residents but they are affected by not having the correct coverage posted for review and verification that there is RN coverage each day. 3. The current policy and procedure on printing the staffing sheet is written well but staff will need education on how to monitor and edit for accuracy. Staff will be educated by 6/21/19 on how to correctly post the daily staffing coverage sheet. DNS will be auditing for accuracy. 4. The DNS & designated nursing staff will be auditing the staffing data that is posted. We will implement audit starting 6/24/19. DNS & nursing staff will audit	

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 _____	05/22/2019

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 732	Continued From page 16 The facility failed to ensure the posted staffing information was accurate and complete.	F 732	weekly x6, monthly x3, quarterly x3, and PRN. The DNS will submit a report of the monitoring results to the QAPI committee at each meeting. If concerns are identified, continued education and corrective action will be implemented. 5. Compliance will be on 6/26/19.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		6/26/19

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 _____	05/22/2019

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 880	Continued From page 17 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced	F 880		

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 _____	05/22/2019

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 880	Continued From page 18 by: Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control standards for 1 of 3 sampled residents (Resident #46) observed during personal cares. Failure to practice appropriate infection control related to hand hygiene has the potential for transmission of communicable diseases and infections to residents and staff. Findings include: Review of facility policy titled "Hand Hygiene and Handwashing" occurred on 05/30/19. This policy, revised January 2018, stated, ". . . Regular handwashing with soap and warm water is one of the best ways to remove germs, avoid getting sick and prevent the spread of germs to others . . . The guidance on handwashing and glove use for patient care and food service has different goals: Patient care: The goal is to prevent the spread of infection between residents. Handwashing and changing gloves occurs after care is delivered to prevent the spread of organisms to other residents. . . . Procedure . . . During patient care 1. Wash hands with plain soap and water or with anti-microbial soap and water: . . . d. after using the restroom . . . 2. If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol based hand rub for routinely cleaning hands: . . . e. after removing gloves . . ." Observation on 05/29/19 at 10:32 a.m. showed two certified nursing assistants (CNAs) (#7 and #8) transferred Resident #46 from his bed to the toilet with a sit-to-stand lift. The CNA (#7) provided perineal cares after an incontinent	F 880	F880 Infection prevention & control 1. For resident # 46 areas that were touched were disinfected 5/29/19. CNA educated on proper hand hygiene. 2. All residents have potential to be affected by poor hand hygiene which may cause the spread of disease. 3. Current policy & procedure will be reviewed by all nursing staff between 6/17/19 and 6/20/19. Proper hand hygiene will be encouraged to be monitored by peers. 4. DNS and designated nursing staff will audit hand hygiene practices weekly x 4, monthly x 3, quarterly x 2 and PRN. We will start auditing 6/24/19. Nursing staff & DNS will report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, who will review and look at trends to make recommendation as needed. If concerns are identified, immediate corrective action will be implemented. The QAPI will use the Model for Improvement for any opportunities for improvement identified. 5. Compliance will be on 6/26/19.	

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 _____	05/22/2019

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 880	Continued From page 19 bowel movement and removed her gloves. The CNAs (#7 and #8) applied a clean brief, pulled up the resident's pants, and transferred him into his recliner. Without performing hand hygiene, the CNA (#7) then turned on music, opened the curtains, and gave the resident the call light. During an interview on 05/21/19 at 4:23 p.m., an administrative nurse (#1) agreed the CNA (#7) failed to practice good hand hygiene.	F 880		