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 _____	08/04/2022

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 08/01/22 and concluded 08/04/22.	F 000		
F 578 SS=D	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 individual's resident representative in accordance	F 578		9/8/22

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

Electronically Signed | 08/21/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 578	Continued From page 1 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 record review, policy review, and staff interview, the facility failed to ensure the residents' right to request, refuse, and/or discontinue treatment for 2 of 14 sampled residents (Resident #25 and #79) reviewed for advance directives. Failure to discuss the residents' resuscitation status with the resident and/or the resident's representative and ensure the medical record accurately reflected each resident's code level limited the facility's ability to communicate to direct care staff and emergency personnel the residents' choice in the event of a medical emergency. Findings include: Review of the facility policy titled "Advance Care Planning" occurred on 08/04/22. This policy, dated 08/25/21, stated, "At the time of admission or re-admission, social services or designated staff member will inform the resident/healthcare decision-maker of the right to consent to or refuse medical treatment and provide copies of this policy . . . asks the resident/healthcare decision-maker whether he or she has prepared an advance directive . . . a copy will be scanned in the medical record. Social services will provide an explanation of advance care planning . . . a meeting will be set up within seven days to begin	F 578	F578 1. Advanced Directives and will be completed for Resident #25 and #79 by the MDS coordinator and/or designee by 8/4/2022. 2. All other residents have the potential to be affected for Advanced Directives and code status. 3. Social Services and /or designee will inform the resident /healthcare decision maker of the right to consent to or refuse medical treatment and provide copies of the policy that asks the resident and/or healthcare decision maker whether he or she has prepared an advanced directive and a copy will be scanned in the medical record. Social Services will provide an explanation of advance care planning with a meeting that will be set up within 7 days begin discussions about their wishes. The designated staff member will meet with the resident/healthcare decision maker to answer questions and determine if he or she wishes to develop or amend advanced directives. All advance care planning discussion including the decision not to proceed with developing or amending advanced directives will be	

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F 578	Continued From page 2 discussions about their wishes . . . The designated staff member will meet with the resident/healthcare decision-maker to answer questions and determine if he or she wishes to develop or amend advance directives. All advance care planning discussions including the decision not to proceed with developing or amending advance directives must be documented in the medical record . . . Once the staff member has determined the wishes . . . the physician will be notified of the resident's wishes and asked to give orders. . . ." Review of Residents #25 and #79's medical records occurred all days of survey. The records lacked a physician's order regarding code status and documentation the facility staff discussed advanced directives with the residents or resident representatives, including their choice regarding cardiopulmonary resuscitation (CPR). The facility failed to obtain documentation of the residents' wishes. During an interview on 08/02/22 at 12:48 p.m., an administrative nurse (#1) verified Resident #25 and #79's records lacked documentation of their code status wishes. At 1:18 p.m., this nurse obtained Resident #25's Medical Orders for Life-Sustaining Treatment (MOLST) form from the clinic, signed by resident on 6/19/22 for "CPR Order: Attempt CPR". The nurse stated staff should have addressed Resident #25's code status on admission (34 days earlier) and obtained an order.	F 578	documented in the medical record. Once the staff member has determined the wishes the physician will be notified of the resident□s wishes and request the orders for that resident. All Advanced Directives will be completed for the residents using the North Dakota POLST by the MDS coordinator and/or designee by 9/8/2022. The Polst form will be added to all of the new Admission packets by 8/5/2022. The Interdisciplinary team will review the policy and procedure for Advanced Directives and resident□s resuscitation status by 8/22/2022. 4. Social Services and/or designee will Audit all new admissions for completion and documentation of Advanced Directives weekly X 4, bi-weekly X 2 and monthly X 4. This will be taken to the Quality Assurance team and the QAPI committee with determine when compliance has been sustained. 5. The Advanced Directives and resident□s resuscitation status will reflect each residents□ code level will be completed by September 8th 2022.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		9/8/22

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F 657	Continued From page 3 §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 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: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff reviewed and revised comprehensive care plans to reflect the current status for 1 of 14 sampled residents (Resident #15). Failure to review and revise the care plan related to falls limited staffs' ability to communicate needs and ensure continuity of care.	F 657	F657 1. Care plans will be revised for resident #15 by the Interdisciplinary team by 8/3/2022. 2. All other residents have the potential to be affected with care planning. 3. IDT reviewed all the care plans and made updates by 09/08/22. The Interdisciplinary team will be educated by the Director of Nursing and/or designee	

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F 657	Continued From page 4 Findings include: Review of the facility policy titled "Comprehensive Care Plan and Care Conferences" occurred on 08/03/22. This policy, dated July 2022, stated, ". . . the care plan is driven by identified resident issues/conditions and their unique characteristics, strengths and needs. When implemented in accordance with standards of good clinical practice, the care plan becomes a powerful, practical tool representing the best approach to providing quality care and quality life. . . . Care plans are to be reviewed with each MDS [Minimum Data Set] completed. . . . In addition to updates during a care plan review, care plans must be revised as the resident's needs/status changes. . . ." - Observations of Resident #15 showed: * 08/01/22 12:10 p.m. In dining room seated in wheelchair with Hoyer (total body mechanical lift) sling placed under resident * 08/02/22 8:38 a.m. Resident in room seated in wheelchair with Hoyer sling present under resident * 08/02/22 11:47 a.m. Staff transported resident in wheelchair to dining room with Hoyer sling present under resident Review of Resident #15's medical record occurred on all days of survey. The current care plan, stated, "The resident has had actual falls R/T [related to] . . . Gait/balance problems, and history of several falls . . . do not leave sling under resident while in w/c [wheelchair] as could cause slipping that could cause or contribute to fall. 02/22/22. . . ."	F 657	on care plans , documentation and Policy and Procedure by 9/8/2022. The Interdisciplinary team will determine the changes for care plans by reviewing care plans weekly and at care plan conferences with the resident and/or healthcare decision maker to make any necessary changes for resident care. The changes will be documented by the interdisciplinary team in the care plan section of Point Click Care. 4. The Interdisciplinary team will Audit 3 care plans weekly X4, bi-weekly X2 and monthly X 4 months. These audits will be taken to the Quality Assurance team by the Director of Nursing; QAPI will determine when compliance has been sustained 5. The plan of correction will be completed by September 8, 2022.	

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F 657	Continued From page 5 Progress notes showed falls on 01/06/22, 02/06/22, 02/10/22, and 02/15/22. An unwitnessed fall on 02/22/22 resulted in an abrasion to the resident's left forehead. Staff educated to remove sling from underneath the resident while in his/her wheelchair. During an interview on 08/03/22 at 4:45 p.m., an administrative staff member (#1) agreed staff failed to update the care plan to the current intervention to leave the sling in place beneath the resident.	F 657		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution	F 761		9/8/22

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F 761	Continued From page 6 systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and staff interview, the facility failed to ensure the safe and secure storage of drugs and biologicals in 1 of 2 medication carts (South cart) observed. Failure to lock the medication cart may result in unauthorized access to medications. Findings include: Review of the facility policy titled "Medications: Acquisition Receiving Dispensing and Storage" occurred on 08/04/22. This policy, revised 02/08/22, stated, ". . . Medications will be stored in a locked medication cart, drawer or cupboard. . . ." - Observation on 08/03/22 from 12:41 p.m. - 12:46 p.m. showed an unlocked medication cart located in the South Hall. Observation also showed unsecured medication (Lasix [diuretic] and Colace [laxative]) on top of the med cart. Staff members and residents walked by the unlocked and unattended medication cart. - Observation on 08/03/22 from 12:50 p.m. - 12:59 p.m. showed an unlocked medication cart located in the South Hall. Staff members and residents walked by the unlocked and unattended medication cart. During an interview on the morning of 08/04/22, an administrative staff member (#1) stated she expected staff to lock the medication cart when left unattended.	F 761	F761 1. The employee # 1 that left the medication cart unlocked and unattended will be educated by the DNS and/or designee by 8/5/2022. 2. All staff and residents have the potential to be affected for the unattended medication cart. 3. All nursing staff that pass Medications will be educated by the DNS and/or designee in regards to leaving the medication carts unlocked and unattended by the DNS by 8/10/2022. 4. An audit for medication carts unattended and unlocked will be completed by the DNS and/or designee 2x weekly for 4 weeks and monthly X 4 months. The audits will be taken to the Quality Assurance team monthly for 1 month for review and compliance. 5. The plan of correction will be completed by September 8th 2022.	

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