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 _____	04/05/2017

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 04/03/17 and completed on 04/05/17, the sample included three (3) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review.	F 000		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility procedure, and staff interview, the facility failed to assess the safety of self administration of medications (SAM) for 2 of 3 sampled residents (Resident #5 and #7) with physician orders to self administer medications. Failure to determine if SAM is a safe practice for each resident has the potential to result in a medication error and/or harm to residents. Findings include: Review of the facility procedure titled "RESIDENT SELF-ADMINISTRATION OF MEDICATION" occurred on 04/05/17. This policy, revised July 2014, stated, ". . . 1. Complete the Resident Self-Administration of Medications . . . to determine if the resident can safely administer medications . . ." - Review of Resident #7's medical record occurred on all days of survey. Diagnoses	F 176	1. A) For Resident #7 an Initial Resident Self-Administration of Medication (SAM) User defined Assessment(UDA)was completed on 4/4/17. B) For Resident #5 an Initial Resident Self-Administration of Medication UDA was completed on 4/22/17. The SAM UDA will be used to review Self Administration quarterly addressing the Resident's safety in the notes of the quarterly SAM. 2. A) All residents who express a desire to Self-Administer meds have the potential to be affected. B) All residents with a Physician order to Self-Administer meds will be audited to make sure that they have had an Initial Self Administration of Medication User Defined Assessment (UDA) done by 4/26/17. 3. A) All residents that request to exercise their right to self-administer drugs will be	5/9/17

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

Electronically Signed | 04/27/2017

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 176	Continued From page 1 included Hemiplegia affecting left side and toxic effect of venom of bees. Allergies included bees. Medications included EpiPen 2 - Pak solution Auto injector for allergic reaction to bee sting. Physician orders included, "may keep EpiPen in locked box in resident remove [sic] for self administration as needed and she will notify staff of use. Lock box will be checked weekly (Sundays)." Resident #7's medical record lacked a SAM assessment. Observation on the morning of 04/04/17 showed a locked box located in Resident #7's room. This box contained an expired Epi-pen. Refer to F431. During an interview on on 04/04/17 at 11:00 a.m. a supervisory nurse (#2) confirmed staff failed to complete a SAM assessment for Resident #7. - Review of Resident #5's medical record occurred on all days of survey. The physician's orders identified "May self-administer medications after set up by charge nurse in dining room and resident room." Review of the current care plan stated, ". . . Focus: The resident chooses to self-administer medications as E/B [evidenced by] demonstrated ability to safely administer after set up by Charge Nurse per interdisciplinary team determination and physician's order. . . . Interventions: Resident will administer medication after set up by CN [charge nurse] in dining room and in resident room. . . ." Review of the "Resident Self-Administration of Medications" assessment, dated 03/30/17, lacked a "Resident Safety Assessment" which included "2 . . . resident requested to	F 176	assessed using the Resident Self Administration of Medication (SAM) UDA in electronic record. 1) Initially on Admission and 2.) SAM UDA reviewed quarterly and/or Significant Changes. The interdisciplinary team will make the decision by the time the Care plan is completed with in the 7 days after the comprehensive assessment. B) MDS Coordinators will review the current policy/procedure for Resident Self-Administration of Medications and the Resident Self-Administration User Defined Assessment (UDA) by 4/26/17. 4. A) The MDS Coordinators will develop an audit to monitor that an Initial SAM UDA's are completed and quarterly SAM UDA's are completed every week x 4, and then monthly x 2, and then quarterly x 2, following with PRN audits as needed. B) MDS Coordinators will submit audits starting 4/28/17 to the DON, who will then report to the QAPI Committee monthly for compliance, 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.	

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F 176	Continued From page 2 self-administer, the resident's cognitive status, the ability of the resident to identify their medications? . . . any memory issues that may impair the resident's ability to self medicate . . . able to identify their medications . . . when to take medications . . . any physical limitations . . . What, if any, accommodations are able to be made? . . . 4. Determination of Interdisciplinary Team . . . 5. Self-Administration Planning . . . " The form however did conclude no "changes in the resident since the original assessment" without the assessment. During an interview on 04/05/17 at 8:05 a.m., when asked to review Resident #5's completed "Resident Self-Administration of Medications" assessment, an administrative nurse (#1) stated the facility did not have a completed assessment.	F 176		
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide medically-related social services for 1 of 9 sampled residents (Resident #9) with a diagnosis of depression. Failure to address the psychosocial needs of Resident #9 and develop and implement interventions related to these needs may be detrimental to the resident's psychological and mental well-being and may negatively affect the resident's overall level of functioning.	F 250	1) Reviewed the chart, medication and care plan for Resident #9 4/14/17. Completed Suicide Risk Assessment 4/18/17. Interviewed resident and spouse 4/18/17. 2) All Residents having suicidal ideation have the potential to be affected. All resident□s charts reviewed for mood and behavior notes to check for suicidal episodes completed 4/14/17. No other	5/9/17

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F 250	Continued From page 3 Findings include: Review of Resident #9's medical record occurred on April 05, 2017. Diagnoses included dementia with Lewy bodies, depression, anxiety, and mood disorder. The Minimum Data Set (MDS), dated 01/06/17, identified short and long-term memory problems and severely impaired decision making. The current care plan stated, ". . . Focus: The resident uses antidepressant medication R/T [related to] Depressive disorder . . . Interventions: Report to Nurse symptoms such as: nervousness, insomnia, headache, nausea, diarrhea, dry mouth, anorexia, muscle pain, dizziness . . ." A nurse's progress note, dated 04/29/16 at 9:53 p.m., stated, "CNA [certified nursing assistant] reports that resident was calling out and saying that he was tired of all this and just wanted to kill himself, author went and spoke with resident and he continues to say he just wanted to die, resident is not capable of self harm due to his medical condition but will be watched through the night and the next shift informed of is [sic] verbaliztion [sic]." During an interview on 04/05/17 at 10:08 a.m., an administrative nurse (#3) stated she would expect social services informed and implement appropriate interventions. The facility failed to develop an interdisciplinary approach to monitor for changes in Resident #9's behaviors and/or suicidal ideation.	F 250	residents have been identified. 3) A) Educate all staff to GSS policy for suicidal precautions. B) Facility now has a Social Worker Designee hired 6/7/16. C) Social Worker Designee will be re-educated to Medically Related Services by Nurse Consultant 4/28/17. D) Social Worker Designee will check PCC Mood and Behavior section for suicidal incidents and implement suicidal policy and procedure. E) Social Worker Designee will facilitate Behavior Meeting monthly. F) Clinical team and Social Worker are responsible to check the behavior alerts daily. 4) A) Social services Designee will develop and audit to monitor all mood and behavior notes Weekly x 4, monthly x2 and quarterly x2 then PRN as needed. B) The Social Services Designee will submit audits starting 5/1/17 to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, 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.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274		5/9/17

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F 274	Continued From page 4 (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: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to complete a significant change in status assessment (SCSA) for 3 of 12 sampled residents (Residents #2, #4, and #6) reviewed. Failure to determine the need for and complete a SCSA in response to a resident's decline or improvement limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate interventions. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.13), dated October 2015, page 2-20 stated, ". . . A "significant change" is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision	F 274	1. A) For Resident #2 a Significant Change in Status Assessment (SCSA) for improvement was completed with ARD of 4/20/17. B) For Resident #4 on 4/20/17 a late entry MDS progress note was written for 1/16/17 stating ADL□s vary and why a SCSA wasn□t completed for Quarterly MDS dated 1/13/17. Moving forward progress notes will be written explaining why SCSA are not done when ADL's vary. C) For Resident #6 a Significant Change in Status Assessment (decline) was completed with an ARD of 4/20/17. 2. All residents who have a significant decline or improvement in their status and meet the definition of a Significant change have the potential to be affected. 3. A) The Long Term Care Facility Resident Assessment Instrument (RAI) User□s Manual procedure and	

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F 274	Continued From page 5 of the care plan. . . ." and page 2-23 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . [such as] increase in the number of areas where behavioral symptoms are coded as being present and/or frequency of a symptom increases . . . Any decline in an ADL [activity of daily living] physical functioning area where a resident is newly coded as Extensive assistance . . ." - Review of Resident #2's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 03/20/17, identified the resident was independent with no staff support for bed mobility, transfers, and ambulation. An admission MDS dated 12/27/16, identified the resident required extensive assistance of 1 for bed mobility, transfers, and ambulation. During an interview on 04/04/17 at 3:28 p.m., a supervisory staff member (#2) verified that a significant change MDS should have been completed to reflect improvement in Resident #2's status. - Review of Resident #4's medical record occurred on all days of survey. A quarterly MDS, dated 10/14/16, identified the resident required extensive assistance of one person for bed mobility and walking in the room. A quarterly MDS, dated 01/13/17, identified the resident required limited assistance of one person for bed mobility and required supervision of one person for walking in the room. During an interview on 04/04/17 at 11:00 a.m. a	F 274	information involving Significant Change in Status Assessment (page 2-20 and 2-23)will be reviewed by the Unit Manager/MDS Coordinator 4/26/17. B) The nursing department will be in-serviced b/w 4/19/17- 4/28/17 regarding what triggers a significant change so they can communicate changes to the Unit Managers. C) The MDS Coordinator will review the High Risk Progress notes and Resident 24 hr. Communication Kardex to identify a resident exhibiting a significant change according to the RAI definition. D) MDS Coordinator/Social Services will review, ADLs, mood, behavior status when completing interviews prior to scheduled assessments. The MDS will be refreshed and current ADL score or new RUG Rate will be compared to prior MDS to monitor for significant Changes that may have occurred. 4. A) The MDS Coordinators will develop an audit to monitor for possible significant changes on MDS assessments every week x 4, then monthly x 2, and then quarterly thereafter for one year, following with PRN audits as needed. B) The MDS Coordinators will submit audits starting 4/28/17 to the DON, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, trends to make recommendation as needed. If concerns are identified, immediate corrective action will be implemented. The QAPI will use the	

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F 274	Continued From page 6 supervisory staff member (#1) stated Resident #4 activities of daily living (ADLs) vary, thus the coding of the MDS as noted. - Review of Resident #6's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 12/21/16, identified the resident required supervision for ADL and no staff support for bed mobility, transfers, walking in the room, and personal hygiene. A quarterly MDS, dated 03/22/17, identified the resident required extensive assistance of two or more persons for bed mobility, transfers and walking in the room; and extensive assistance of one person for personal hygiene. During an interview on 04/04/17 at 3:20 p.m. a supervisory staff member (#1) stated the resident ADLs vary "so much" which resulted in the change in coding, verified no interval note was made, and agreed a significant change MDS for the decline should have been done.	F 274	Model for Improvement for any opportunities for improvement identified.	
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed.	F 278		5/9/17

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F 278	Continued From page 7 (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 1.14), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 4 of 12 sampled residents (Resident #1, #2, #4, and #5). Failure to accurately complete Section H (bladder and bowel) (Resident #4 and #5) and Section O (special treatments, procedures, and programs) (Resident #1 and #2) 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.	F 278	1. A) Resident #1: Modified the quarterly MDS, dated 02/10/17 changing O0250C to Code 2 received influenza outside of this facility during vaccination season. B) Resident #2: Modified a quarterly MDS dated 03/20/17, changing O0250C to Code 2 received influenza outside of this facility during vaccination season. C) Resident #4: Modification to MDS 1/13/17 changing H0300 to 9 not rated. D) Resident #5: Reviewed Annual MDS with ARD of 9/23/16 H0600 and MDS progress note documented 4/20/17 as Late Entry 9/26/16.	

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F 278	Continued From page 8 Findings include: BLADDER AND BOWEL The Long-Term Care Facility RAI User's Manual (version 1.14), revised October 2016, Chapter 3 page H-8, stated, "H0300: Urinary Continence . . . Coding Instructions . . . Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter . . . for the entire 7 days." Page H-12 and H-13, stated, ". . . H0600: Bowel Patterns . . . Definition: Constipation: If the resident has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass . . . Steps for Assessment . . . 2. Residents who are capable of reliably reporting their continence and bowel habits should be interviewed. . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included retention of urine. The current care plan stated, "Focus: The resident has indwelling catheter R/T [related to] Neurogenic bladder/urinary retention/Renal Tumor . . . Interventions: CATHETER: Resident has Urinary foley Catheter. . . ." A quarterly MDS, dated 10/14/16 and an annual MDS, dated 01/13/17, identified Resident #4 had an indwelling catheter and was continent of urine. The MDSs reflected continence of urine with the use of an indwelling catheter verses coding of a 9 for not rating of continence. During an interview on 04/04/17 at 11:00 a.m., an administrative nurse (#1) confirmed Resident #4	F 278	2. A) All residents identified with a urinary catheter will have the MDS evaluated for accuracy in Section H0300 prior to submission. B) All residents receiving or have received Immunizations will have the MDS evaluated for accuracy of Section O0250C prior to submission. C) All residents with the RAI definition of constipation in the RAI 7 day look back or have a care plan focus of constipation will have the potential to be affected. 3. A) The facility will ensure that the MDS section O0250C, H0300, and H0600 are coded accurately and have proper back up documentation in the electronic record. B) THE MDS Coordinators and DON will be in-serviced regarding the RAI definitions for coding and proper documentation needed for section H and Section O by reviewing the RAI section H0300 and H0600 on pages H-8, H12-13 and RAI section O0250C on pageO-8 by 4/26/17. C) All residents will have the last Comprehensive MDS 7-day look-back period revisited and H0600 evaluated for constipation and MDS modified if necessary. 4. A) The MDS Coordinators will develop an audit to monitor for possible coding errors on MDS assessments for sections H and O, every week x 4, then monthly x 2, and then quarterly thereafter for one year, following with PRN audits as	

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F 278	Continued From page 9 had an indwelling catheter during the MDS look-back periods. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included constipation. An annual Minimum Data Set (MDS), dated 09/23/16, identified constipation not present during the look-back period. Review of Resident #5's bowel movements during the look-back period showed no bowel movements documented. During an interview on 04/04/17 at 4:44 p.m., an administrative nurse (#1) stated Resident #5 does not like to be asked about bowel movements so the staff do not ask him. The medical record lacked evidence staff monitored Resident #5 for bowel habits. INFLUENZA VACCINE The Long-Term Care Facility RAI Manual (version 1.14), revised October 2016, Chapter 3 page O-8, stated, "O0250C: If influenza vaccine not received, state reason. . . . Code 2, Received outside of this facility: includes influenza vaccinations administered in any other setting (e.g., physician office, health fair, grocery store, hospital, fire station) during this year's influenza vaccination season. . . ." - Review of Resident #1's medical record occurred on all days of survey. An admission MDS, dated 12/23/16, and a quarterly MDS, dated 02/10/17, identified Resident #1 did not receive an influenza vaccine and was not in the facility during the influenza vaccination season. The medical record identified Resident #1	F 278	needed. B) The MDS Coordinators will submit audits starting 4/28/17 to the DON, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, 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.	

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F 278	Continued From page 10 received the influenza vaccine prior to admission. - Review of Resident #2's medical record occurred on all days of survey. An admission MDS dated 12/27/16 and a quarterly MDS dated 03/20/17, identified Resident #2 did not receive an influenza vaccine and was not in the facility during the influenza vaccination season. The medical record identified that Resident #2 received the influenza vaccine prior to admission. During an interview on 04/05/17 at 11:00 a.m., an administrative nurse (#2) confirmed Resident #1 and Resident #2 had received the influenza vaccine prior to admit and section O0250C had been incorrectly coded on the MDS.	F 278		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (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: Based on record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure staff reassessed the response to as needed (PRN) pain medications in a timely manner for 1 of 7 sampled residents (Resident #1) identified receiving PRN pain medications. Failure to timely reassess after administering a PRN pain medication limits the ability for staff to assess the effectiveness of the pain medication and may	F 281	1. For Resident #1 the effectiveness of PRN medication is being documented and timely per facility procedure. 2. All residents receiving PRN medications have the potential to be affected. 3. A) The current procedure Documentation of Medication has been	5/9/17

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F 281	Continued From page 11 result in the resident experiencing unrelieved pain. Findings include: Review of the facility policy titled "Documentation of Medication" occurred on 04/05/17. This policy, revised 09/15, stated, ". . . To document medication correctly. . . . 5. Reason for administration if PRN drug given and resident response or effectiveness of the medication. . . ." Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice." 10th ed., Pearson Education Inc., New Jersey, page 1109, stated," . . . NURSING RESPONSIBILITIES *Assess pain prior to and 60 minutes after administration . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included osteoarthritis, pain unspecified, non displaced fracture of surgical neck of right humerus, and left and right hip fracture with pinning. Physician orders included oxycodone 5 milligrams (mg) every six hours PRN for moderate pain, Tylenol extra strength 500 mg every four hours PRN for mild pain, tramadol 50 mg every six hours PRN for pain, Tylenol 325 mg every four hours PRN for pain, and tramadol 25 mg as PRN one time a day for pain. Review of Resident #1's medication record and progress notes for December 20 through March 31, 2017 identified the following: * December: On 17 occasions staff administered PRN Tylenol and on seven occasions staff assessed the efficacy of Tylenol 2 1/2 to 4 hours	F 281	reviewed. Charge nurses will be in-serviced between 4/19 □ 4/26/17, on the importance of accurate and timely documentation of the effectiveness of PRN medications with the goal to chart within 60 minutes after administration. 4. A) The Director of nursing or designee will develop an audit to monitor PRN follow-up documentation regarding accuracy and timeliness: weekly x 4 weeks, monthly x 3 months and then quarterly thereafter for one year. B) The Director of Nursing or designee will submit audits starting 4/28/17 to the DON, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, 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.	

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F 281	Continued From page 12 after administering the medication. On 15 occasions staff administered PRN oxycodone and on 3 occasions the staff assessed the efficacy of the oxycodone 2 1/2 to 3 hours after administrating the medication. * January: On 3 occasions staff administered PRN oxycodone and on 2 occasions the staff assessed the efficacy of the oxycodone over 2 hours after administering the medication. On 17 occasions staff administered PRN Tylenol and on 7 occasions the staff assessed the efficacy of the Tylenol 2 1/2 to 3 hours after administering the medication. On 28 occasions staff administered PRN tramadol and on 6 occasions the staff assessed the efficacy of the tramadol 2 to 4 hours after administering the medication. * February: On 15 occasions the staff administered PRN tramadol and on 3 occasions staff assessed the efficacy of the medication 2 to 3 hours after administering the medication and one occasion staff failed to document any follow-up. On 16 occasions the staff administered PRN Tylenol and on 2 occasions staff assessed the efficacy 2 1/2 to 4 hours after administering the medication. * March: On 4 occasions the staff administered PRN Tylenol and on 1 occasion the staff assessed the efficacy 2 1/2 hours after administering the medication. On 5 occasions the staff administered PRN Tramadol and on 2 occasions the staff failed to assess the efficacy 3 to 4 hours after administering the medication.. During an interview on 04/05/17 at 11:00 a.m., an administrative nurse (#3) stated staff are to document the effectiveness of the PRN pain medication in the progress notes within 1 hour after administration of the medication.	F 281		

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F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 309		5/9/17

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F 309	Continued From page 14 by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to ensure monitoring of the status of bowel movements in order to identify symptoms of constipation for 4 of 12 sampled residents (Resident #3, #5, #8, and #11). Failure to monitor residents' bowel status/elimination may result in delay of interventions to manage constipation, the need for rectal suppositories or enemas, and may result in the resident's experiencing fecal impactions. Findings include: Review of the facility policies occurred on 04/05/17: * The "Bowel Assessment" policy, dated 09/12 stated: "Purpose: To assess bowel function appropriately; To identify effective bowel management programs . . . Prevention of constipation and fecal impaction is critical. Failure to accurately assess the abdomen has led to unnecessary death of residents. . . ." * The "GSS [Good Samaritan Society] MOHALL BOWEL PROTOCOL," dated 03/06/16, stated, "1. The 'No BM [bowel movement] Alert Report will be reviewed each evening along with the 'Clinical Alert Report'. 2. A BM list will be made, listing all resident's that have NOT had a BM x [times] 2 days. If no BM x 2 days (pm [evening] shift) then a bowel aide will be given like prunes, prune juice, fruit ball, or MD [medical doctor] order for bowel aide. . . . If no BM on the 3rd day - get MD order for Milk of Magnesia 30 ml [milliliter] po [oral] or other MD order for bowel	F 309	1. A) Resident #5 had bowel assessment completed 4/22/17. Educated and will now let staff ask about bowel function. B) Resident #3 had bowel assessment completed 4/22/17. Staff recording bowel function according to facility procedure. C) Resident #8 had bowel assessment completed on 4/25/17, developed individualized bowel protocol and revised care plan. D) Resident #11 had bowel assessment completed on 4/25/17, developed individualized bowel protocol and revised care plan. 2. A) All residents who have 2 or fewer BM□s during a 7 day MDS look back period or have been without bowel movement for 3 days have the potential to be affected. 3. A) The current policy/procedure for Bowel assessment, the definition of constipation and Bowel Protocol was reviewed with Unit Managers and Charge Nurses between 4/19 □ 4/26/17. B) The nursing department staff will be in-serviced regarding proper documentation of all bowel function every shift in the POC or PCC electronic record between 4/19- 4/26/17 or next scheduled shift. C) New System: Residents who prefer not to be asked about Bowel function will be care planned with a Potential for constipation focus so they will be	

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F 309	Continued From page 15 aide. If no BM on the 4th day (morning) give Dulcolax supp [suppository], Fleets enema, or other MD order for bowel aide. . . ." The protocol continued to specify the interventions to follow for a resident with no BM for two, three, and four days. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included constipation. The physician's orders identified Miralax 17 grams as needed for constipation. Review of the bowel movement records for the month of March through April 4, 2017, showed Resident #5 had four bowel movements and up to 19 days between bowel movements. The MAR identified Resident #5 did not receive PRN bowel medications and lacked evidence the resident received other interventions. During an interview on 04/04/17 at 4:44 p.m., an administrative nurse (#1) stated Resident #5 does not like to be asked about bowel movements so the staff do not ask him. - Review of Resident #3's medical record occurred on all days of survey. Medications included a physician's order, dated 03/03/17, for Milk of Magnesia (MOM- laxative given by mouth) as needed for constipation and to "Contact provider/practitioner if there are three days without a significant BM. . . ." Resident #3's quarterly MDS, dated 12/29/16, identified cognitively intact, continent of bowel, and required extensive assistance of one person for toileting. The current care plan identified the	F 309	educated to notify nurses regarding problems with bowel function, reviewed quarterly and/or with Sig changes. 4. A) The Director of Nursing or designee will develop an audit to a) monitor bowel function documentation and b) proper use of the Bowel protocol every week x 6 weeks, monthly x 3, and then quarterly thereafter for one year, following with PRN audits as needed. B) The Charge nurses or designee will submit audits starting 4/28/17 to the DON, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, 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.	

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F 309	Continued From page 16 resident required assistance from one person for toileting. Review of Resident #3's bowel movement records for the month of March through April 4, 2017, identified no bowel movement (BM) for two days on one occasion, no BM for three days on two occasions, no BM for five days on one occasion, and no BM for seven days on one occasion. The medication administration record (MAR) during this time frame identified nursing staff administered MOM on the second day without a BM on 03/03/17, and on the fifth day of no BM on 03/15/17. The next BM documented occurred three days after the resident received the MOM, identifying a total span of seven days without a BM. The record lacked evidence nursing staff assessed the resident for constipation and provided consistent measures, per a plan of care or protocol, to address Resident #3 for constipation. During an interview on 04/05/17, a supervisory staff member (#1) confirmed the medical record included a span of up to seven days between BMs. The facility failed to assess, monitor and ensure the implementation of timely measures based on the resident's BM status to avoid constipation problems. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included constipation, dementia, and depression. Medications included Dulcolax Suppository and MOM as needed for constipation.	F 309		

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F 309	Continued From page 17 Review of Residents #8's bowel movement records for February through March 31, 2017, identified no BM for four days on two occasions, for five days on two occasions, and for seven days on one occasion. The MAR during this time frame identified the administration of a Dulcolax suppository on the fifth day on two occasions without a BM. The record lacked evidence staff attempted other measures to address Resident #8's constipation. - Review of Resident #11's medical record occurred on April 5, 2017. Diagnoses included dementia and constipation. Medication included MiraLax powder by mouth as needed and Dulcolax suppository as needed. On 03/29/17 MiraLax was changed to one time daily. Review of Resident #11's bowel movement and MAR records for February through March 31, 2017 identified no BM for four days on three occasions and no BM for 5 or more days on two occasions. The record lacked evidence staff attempted other measures for Resident #11's constipation as on six occasions staff administered a Dulcolax without first attempting the PRN MiraLax. The facility failed to implement a bowel protocol for each resident based on their individual needs, including specifying when to administer physician ordered laxatives/bowel stimulants.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -	F 323		5/9/17

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F 323	Continued From page 18 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 2 of 3 sampled residents (Resident #1 and #6) observed during gait belt transfers. Failure to use the gait belt properly (Resident #1), and provide adequate assistance (Resident #6), during transfers placed the residents at risk of accidents and injury. Findings include: Review of the facility policy titled "Gait (Transfer)	F 323	1. A) Resident # 1 will have gait belt placed properly when transferred according to facility procedure. B) Resident #6 had a Mobilization Support data Collection tool completed 4/20/17 and Care plan revised to provide adequate assistance with all transfers. 2. All residents who need physical assistance when transferring have the potential to be affected. 3. A) Nursing department staff will be in-serviced on proper gait belt application	

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F 323	Continued From page 19 Belt" occurred on 04/05/17. This policy, revised March 2017, stated, ". . . 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. This will prevent the belt from sliding up under the breasts, rib cage or axillae. . . . When holding the belt, an underhand grasp should be used. . . ." -Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance, osteoarthritis, pain, history of (healed) traumatic left hip fracture, osteoporosis, and nondisplaced fracture of the right arm. The quarterly Minimum Data Set (MDS), dated 02/10/17, identified the resident required extensive assist of two or more staff for transfers. Resident #1's current care plan stated, ". . . fracture to right humeral head and neck junction R/T [related to] osteoporosis. . . . Handle gently when moving or positioning. Keep shoulder immobilizer in place as she allows. . . . Resident has an ADL [activities of daily living] self care performance deficit . . . required need of gaitbelt . . ." Observation on 04/03/17 at 3:47 p.m., showed two certified nursing assistants (CNAs) (#6 and #7), transferred Resident #1 from her bed to the wheelchair using a gaitbelt. The CNA's (#6 and #7) placed the gaitbelt around Resident #1's waist and as the CNA's (#6 and #7) raised Resident #1 to a standing position, the gaitbelt slid up the Resident's back. The CNA's (#6 and #7) immediately sat the resident back down due to her complaint of pain and inability to fully	F 323	b/w 4/19-4/26/17. B) DON will review with the Unit Managers and Charge Nurses that an unlicensed staff member (CNA) cannot make the determination or assess when to utilize 1 or 2 staff for a transfer based on if the resident is feeling weak or is uncooperative and Care plans will need to reflect that, b/w 4/19-4/26/17. C) Unit managers will review all residents ADL care plans requiring staff assist, and review/assess as necessary. 4. A) The Director of Nursing or designees will audit proper application of the gait belt by staff, starting 4/28/17, weekly x 4, and then monthly x 2, quarterly x 3 and PRN as needed. B) Unit Managers will audit ADL care plan approaches starting 4/28/17 regarding transfer assistance weekly x 4, monthly x 2 and quarterly thereafter for one year. C) The DON or designee will submit audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, 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.	

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stand. The CNAs (#6 and #7) raised Resident #1 to a standing position for a second time and the gaitbelt slid up the resident's back. During both transfers, the CNA (#7) was observed to hold the gaitbelt with one hand and lift under the resident's axillae with the other hand. While the CNA's (#6 and #7) transferred the resident to the toilet and back to her wheelchair, the gaitbelt slid up Resident #1's back and under her arms. The staff failed to readjust or tighten the gaitbelt between all transfers.

Observation on 04/04/17 at 2:49 p.m. showed two CNAs (#6 and #7) applied a gaitbelt to Resident #1's waist and assisted her to a standing position. During the transfer, the gaitbelt slid up the resident's back and under her arms. The resident was transferred to the bathroom and to the toilet utilizing a gaitbelt. As the CNAs (#6 and #7) assisted the resident to a standing position, the gaitbelt slid up Resident #1's back. The staff failed to readjust or tightened the gait belt during or between transfers.

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included osteoporosis, osteoarthritis, legal blindness, and dementia with behavioral disturbances. The quarterly MDS, dated 03/22/17, identified the resident with short and long term memory problems, and extensive assistance of two or more staff for transfers.

Resident #6's current care plan identified the following problems:
* ". . . limited physical mobility R/T COPD [chronic obstructive lung disease], Arthritis and O2 [oxygen] use E/B [evidenced by] fatigue,

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weakness" with interventions including "MOBILITY: Resident is able to walk with 1 staff assist in room with wheeled walker. She does require supervision and assist with O2 tubing at times. . . ."
* ". . . ADL [activities of daily living] self care performance deficit R/T Oxygen use, Arthritis E/B Activity intolerance, Limited mobility" with interventions including ". . . TOILET USE: Resident needs assist of 2 with toileting. . . . TRANSFER: Resident needs 1 staff assist with transfers now as is allowing use of gaitbelt. May use 2 staff if she is feeling weak or is uncooperative. . . ."
* ". . . at risk for falls R/T Vision/hearing problems and use of O2" with interventions including "Educate resident about safety reminders and what to do if a fall occurs. Remind resident to use her walker when ambulating and call for assistance when needed. . . . Monitor resident for significant changes in gait, mobility, positioning device, standing/sitting balance and lower extremity joint function. . . . Monitor visual and auditory impairments. . . . PERSONAL ALARM: Silent Bed Check used to alert staff to resident's movement . . . modify environmental hazards (O2 tubing), that could cause or contribute to fall. Provide assist as [resident] asks. . . ."

Observation on 04/03/17 at 3:35 p.m. showed a CNA (#8) assisted Resident #6 to the bathroom from her bed. Observation showed an extension tubing from an oxygen concentrator placed in a corner of the bathroom. The CNA removed the oxygen cannula and tubing out of the way prior to the transfer. While the resident sat upright in bed, the CNA placed a gait belt around the resident's waist, and assisted the resident to a standing

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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 323	Continued From page 22 position at which time the resident moaned loudly and then sat back down onto her bed. The CNA again assisted the resident to stand and the resident stated, "I'm falling" and made loud vocal noises while walking to the bathroom with her front wheeled walker. After the resident used the toilet, the CNA stood the resident to perform perineal cares and while the resident stood, she stated, "Oh my leg" and "I'm going to fall." During two observations of toileting on the morning of 04/04/17, two CNAs (#9 and #10) assisted with each transfer. During both these observations, Resident #6 began moaning as soon as the CNAs placed the gait belt around her and the resident said "Oh, what a terrible place to live." On both occasions, the resident expressed dislike/discontent when placing and removing the gait belt. Record review identified the resident sustained five falls between 01/21/17 and 03/16/17: * 01/21/17: the resident slipped off the bed to the floor. On the morning of 04/04/17, a supervisory staff member (#1) identified the resident as independent with transfers at that time * 01/22/17: with one staff member present, the staff member assisted the resident to the floor while she was self-transferring from the bed to her wheelchair, the resident complained her left leg gave out. A supervisory staff member (#1) identified the resident independent with transfers at that time, changed her to two staff assist after this, and an attempt made to use a sit-to-stand lift for her transfers was unsuccessful. The staff member stated, on 02/16/17, the resident was doing well with two staff assist so changed the amount of assistance to one staff for transfers.	F 323		

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F 323	Continued From page 23 * 03/05/17: one staff member assisted her to the floor as she wouldn't stand up. * 03/16/17 at 2:54 p.m.: a CNA walked into the resident's room while the resident was headed to the bathroom. While the CNA attempted to place a gait belt, the resident said she was falling. The CNA lowered the resident to the floor without injury. A supervisory staff member (#1) stated it was determined a dizzy spell contributed to this fall, and the physician/provider adjusted her blood pressure medication, and nursing began monitoring the resident's blood pressure. * 03/18/17: the resident sustained a fall in her room unattended. A progress note, dated 03/23/17, stated the care planning team identified the resident at times is able to have the assistance of one but other times she needs two staff due to her legs giving out ". . . several falls this quarter including 3 times she was lowered to floor by staff." A change in the care plan occurred after this meeting to "TRANSFER: Resident needs 1 staff assist with transfers now as is allowing use of gaitbelt. May use 2 staff if she is feeling weak or is uncooperative. . . ." The care plan remained utilizing two staff for toileting. The care plan approach for transferring of the resident allows for the provision of an unlicensed staff member (CNA) to make the determination of when to utilize two staff for a transfer, based on how the resident is feeling at the time as well as knowing prior to the transfer if the resident would be uncooperative. This approach requires the unlicensed staff member to make this assessment for both factors (feeling weak or uncooperative) prior to a transfer. This places	F 323		

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F 323	Continued From page 24 Resident #6 at risk due to not receiving adequate supervision and assistance to prevent accidents including falls.	F 323		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents were free of any significant medication errors for 1 of 12 sampled residents (Resident #5) who did not receive a scheduled medication for multiple days. Failure to ensure the administration of Symbicort (medication for chronic obstructive pulmonary disease) (COPD) and failure to inform the physician regarding the unavailability of the medication may result in a negative outcome for Resident #5. Findings include: Review of the facility policy titled "MEDICATION ADMINISTRATION, INCLUDING SCHEDULING AND MEDICATION AIDES" occurred on April 5, 2017. This policy, revised May 2016, stated, ". . . Medication Errors . . . If a medication is not available for 24 hours, the provider must be notified that the medication is not available and must give direction for how to proceed. . . ." Review of Resident #5's medical record occurred	F 333	1. For Resident #5 will receive Symbicort and other medication as scheduled and if unavailable, Physician will be notified according to facility procedure. 2. All residents that receive medication have the potential to be affected. 3. The current procedures Medication Administration, Including scheduling and Medication Aides, Medication Errors, and Local Pharmacy Medication ordering is being reviewed and Charge Nurses in-serviced regarding procedure b/w 4/19-4/26/17. 4. A) The Director of nursing or designee will develop an audit to monitor that Physician is notified if medication not available in 24 hours as per procedure: weekly x 4 weeks, monthly x 3 months and then quarterly thereafter for one year.	5/9/17

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F 333	Continued From page 25 on all days of survey. Diagnoses included COPD. The current care plan stated, "The resident has altered respiratory status/difficulty breathing R/T [related to] COPD. . . ." Medications included Symbicort inhale two puffs two times a day. The progress notes identified the following: * August 2016: 2 missed doses of Symbicort. * October 2016: 3 missed doses of Symbicort. * November 2016: 7 missed doses of Symbicort. * December 2016: 5 missed doses of Symbicort. * January 2017: 10 missed doses of Symbicort. * February 2017: 1 missed dose of Symbicort. During an interview, an administrative nurse (#1) stated facility staff do not know why Resident #5's Symbicort runs out before the pharmacy will refill the prescription. The facility failed to ensure Resident #5 received his prescribed medication for 28 days and failed to inform the physician regarding the unavailability of the medication.	F 333	B) The Director of Nursing or designee will submit audits starting 4/28/17 to the DON, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, 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.	
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 334		5/9/17

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F 334	Continued From page 26 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 334		

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F 334	Continued From page 27 (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on policy review, record review, and staff interview, the facility failed to assess each resident's pneumococcal status, document refusals for flu and pneumococcal vaccinations, and provide education to residents and/or their legal representatives regarding the benefits and potential side effects of receiving the vaccinations for 2 of 12 sampled residents (Resident #6 and #7). Failure to offer pneumococcal and flu immunization on admission to all residents, provide education to residents and their legal representatives, and document the administration or refusal has the potential for non-immunized residents to contact flu and/or pneumonia and also spread the infection to other residents, visitors, and staff. Findings include: Review of the facility policy titled, "Immunizations for Residents" occurred on 04/05/17. This policy, revised July 2012, stated, " . . . a. Upon admission each resident and / or legal	F 334	1. A) For resident # 7 education regarding the benefits and side effects of the pneumonia immunization was given and the pneumococcal immunization was offered. The resident□s refusal was documented 4/6/17 in the electronic record under the immunization tab. B) For resident # 6 education regarding the benefits and side effects of the pneumonia immunization was verbally explained (can□t see to read) and then the pneumococcal immunization was offered. The resident□s refusal was documented 4/10/17 in the electronic record under the immunization tab. 2. All residents have the potential to be affected. 3. A) The facility will ensure that on admission each residents and/or legal representative will receive the Vaccination Information Statements for influenza and	

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F 334	Continued From page 28 representative will receive the Vaccination Information Statements (VIS) for influenza and pneumococcal vaccines. . . . f. Document refusal of pneumococcal vaccination on the resident's Immunization Record (GSS #212). . . . f. Document that education information was provided to the resident on the resident's Immunization Record . . . h. Document refusal of influenza vaccination (if applicable) on the resident's Immunization Record." - Review of Resident #7's medical record occurred on all days of survey. The resident was admitted on 11/05/15. The medical record lacked evidence the facility assessed the resident's pneumococcal immunization status. During an interview on the afternoon of 04/04/17, an administrative staff member (#3) stated Resident #7 refused the pneumococcal immunization. The medical record lacked documentation of the resident's education and refusal of the immunization. - Review of Resident #6's medical record occurred on all days of survey. The resident was admitted on 06/24/15. A quarterly Minimum Data Set (MDS), dated 03/22/17, identified the facility offered both the flu vaccine and pneumococcal vaccine but the resident declined. The medical record lacked evidence/documentation of the refusals. During an interview on the morning of 04/05/17, an administrative staff member (#3) stated she does not get written consents for the refusals of flu and pneumococcal immunizations. The medical record lacked documentation of the	F 334	pneumococcal vaccines. B) The facility will ensure that the electronic medical record will have documentation that education was provided and documentation whether the resident received the immunization or refused the immunization. 4. A) The Director of Nursing or designee will develop an audit to monitor immunization and education documentation weekly x 4, and then monthly x 3, and then quarterly thereafter for one year, following with PRN audits as needed. Audits will start 4/28/17. B) The DON or designee will submit audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, 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.	

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F 334	Continued From page 29 resident's education and refusal of the immunization.	F 334		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (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.	F 431		5/9/17

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F 431	Continued From page 30 (h) Storage of Drugs and Biologicals. (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. (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 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, record review, and staff interview, the facility failed to properly store medications for 1 of 1 sampled resident (Resident #7) with an EpiPen. Failure to discard an expired Epipen increases the risk of the resident receiving outdated medication with reduced efficacy. Findings include: Review of Resident #7's medical record occurred on all days of survey. Diagnoses included hemiplegia affecting left side and toxic effect of venom of bees. Allergies included bees. Medications included EpiPen 2 - Pak solution Auto injector for allergic reaction to bee sting. Physician orders included, "may keep EpiPen in locked box in resident remove [sic] for self administration as needed and she will notify staff	F 431	1. For resident #7 the out dated Epipen was replaced with Epipen that has an expiration date of 4/5/18 on 4/5/17. 2. All residents that have a locked Medication box in their room have the potential to be affected. 3. New System: Charge nurses will check expiration dates in locked boxes when Resident Self-administration record (GSS# 261) is documented when reconciling the Meds in locked boxes weekly. Charge nurses will be in-serviced b/w 4/19-4/26/17. 4. A) The Director of nursing or designee will develop an audit to monitor	

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F 431	Continued From page 31 of use. Lock box will be checked weekly (Sundays)." Observation on 04/04/17 at 10:55 a.m. with a staff nurse (#5) showed a locked box located in Resident #7's room. This box contained Resident #7's EpiPen with an expiration date of January 2017. The nurse confirmed the medication expired and removed it from the resident's room.	F 431	expiration dates in the locked boxes in resident□s rooms: weekly x 4 weeks, monthly x 3 months and then quarterly thereafter for one year. B) The Director of Nursing or designee will submit audits starting 4/28/17 to the DON, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, 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.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		5/9/17

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F 441	Continued From page 32 (i) A system of surveillance designed to identify 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the	F 441		

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F 441	Continued From page 33 spread of infection. (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 by: Based on record review and staff interview, the facility failed to provide adequate follow-up for 1 of 3 sampled residents (Resident #2) identified with a history of a urinary tract infection (UTI). Failure to follow-up the results of a urine culture and sensitivity (C&S) report, resulted in the resident receiving no treatment for a UTI. Findings include: Review of Resident #2's medical record occurred on all days of survey. Diagnoses included benign prostatic hyperplasia (enlarged prostate) with urine retention. The admission Minimum Data Set (MDS) dated 12/27/16 and the quarterly MDS dated 03/201/7 identified the resident had moderate cognitive impairment. The current care plan stated, ". . . Focus: The resident has indwelling catheter . . . Interventions: . . . Monitor/record/report to health care provider for s/s UTI: pain, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. . . ." Review of Resident #2's progress notes identified the following: * 01/07/17 at 4:41 p.m.: " . . . Foley patent for medium yellow urine with occasional tissue fragments present. . . ."	F 441	1. Resident #2 will have all future abnormal urinalysis followed up and initiation of treatment per Medical provider guidelines. Urine Culture dated 01/11/17 (collected 1/9/17) was shown to Jody Olson FNP-C on 4/5/17 and no treatment or lab ordered due to no symptoms. 2. All residents who have urinalysis or urine cultures have the potential to be affected. 3. A) The initiation of Antibiotics Guidelines will be reviewed with the Charge nurses 4/19-4/26/17. B) An Awaiting Medical Practitioner orders log was created to log all faxes sent by Charge nurses regarding abnormal lab or notification of a resident□s problem. Charge Nurses will be in-serviced 4/19-4/26/17 regarding NEW SYSTEM and to contact Medical practitioner if orders not received back by the next day. 4. A) The Director of nursing or designee will develop an audit to monitor return of faxes sent to the Medical Practitioner: weekly x 4 weeks, monthly x 3 months and then quarterly thereafter for	

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F 441	Continued From page 34 * 01/08/17 at 4:10 a.m.: "Resident confused this NOC [night] shift. Resident uses call light almost every hour on the hour. . . . wanting his leg bag emptied. After emptying leg bag, staff asked resident if he needed anything else, and resident stated he needed his leg bag emptied. Staff reminded resident it was just emptied. . . ." * 01/08/17 at 2:52 p.m.: "[Resident] had increased anxiety early this morning . . . Continue to monitor urine and output, color today is amber w/o [without] blood. Penis is swollen . . ." * 01/09/17 at 10:00 a.m.: "Noting increased confusion, even [Resident] is noting this. Also urine is quit [sic] cloudy with visible blood. Call made to [provider] and orders received for UA [urinalysis] which was collected and sent to lab." * 01/09/17 at 4:18 p.m.: ". . . slight confusion noted at times . . . U/A also collect [sic] and sent to lab d/t [due to] increased confusion and notable blood in urine. . . ." * 01/10/17 at 4:29 p.m.: ". . . Is confused at times . . . Also note that he is losing interest in TV [television] programs that were his favorite and he could tell you every persons name on there and what they are up to and now he is unable to do so, waiting on UA results. . . ." * 01/11/17 at 4:31 p.m.: ". . . Continues with confusion . . . Foley is patent for amber urine w/o tissue shreds or blood, penis remains swollen . . . Watching TV, flips channels and forgets how to change it back to what he wants. . . ." * A urine culture dated 01/11/17, collected 01/09/17, identified the final report of 100,000 cfu(colony forming units)/ ml (milliliter) Methicillin-Resistant Staphylococcus aureus. The form identified staff faxed it to the provider on 01/12/17. * 01/12/17 at 4:22 p.m.: "Got back microbiology	F 441	one year. B) The Director of Nursing or designee will submit audits starting 4/28/17 to the DON, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, 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.	

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 _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 35 report from Urine Culture collected [sic] 1/09. faxed to [provider] along with med [medication] sheets." * 01/12/17 at 5:12 p.m.: ". . . Does have periods of increased confusion and obsession . . . Foley catheter remains patent for yellow urine, no blood or tissue shreds present today, penis remains swollen . . ." * 01/14/17 at 12:54 a.m.: "Resident is very confused about his catheter. Stated that the physician told him that his urine would naturally run and that he did not need his catheter anymore." Resident #2's medical record lacked evidence of any follow-up from the provider regarding the results of the urine culture, and staff failed to follow-up or contact the provider after faxing the culture report to verify if treatment was needed. During an interview on 04/05/17 at 11:00 a.m., an administrative nurse (#2) confirmed Resident #2's medical record lacked evidence of follow-up by the provider or facility staff regarding results of Resident #2's urine culture and lacked evidence the resident received any antibiotic therapy during this time.	F 441		
F 456 SS=D	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents.	F 456		5/9/17

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F 456	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure emergency equipment remained in safe operating condition for 1 of 2 suction machines (North Unit). Failure to ensure the suction machine remained functional in case of an emergency situation placed residents at risk for choking and aspiration. Findings include: Observation of the suction machine stored on the North Unit occurred on 04/05/17 at 10:40 a.m. with a licensed nurse (#4). Observation showed the nurse attempted to suction water from a glass. The suction machine did not produce suction. The nurse checked all the connections and the machine still did not have suction. This nurse requested assistance from a supervisory nurse (#3). After checking the connections the machine did not produce suction. The supervisory nurse stated the machine was not working and a new one would be ordered.	F 456	1. North clean utility suction machine had canister replaced and had proper function 4/5/17. A new Suction machine was purchased to replace the North Clean Utility Suction Machine 4/20/17. 2. All suction equipment has the potential to be effected. 3. A) The facility will ensure that both North and South suction machines are in proper working order. B) The current procedure for Suction machine cleaning was revised on 4/18/17 and Charge Nurses will be in-serviced in revised procedure 4/19-4/26/17. C) Charge Nurse duties were revised 4/22/17 to include turning on the suction machine to assess proper suction by the Night Nurses on Friday night. 4. A) The Director of nursing or designee will develop an audit to monitor that Suctions machines are plugged and turned on to assess proper functioning: weekly x 4 weeks, monthly x 3 months and then quarterly thereafter for one year. B) The Director of Nursing or designee will submit audits starting 4/28/17 to the DON, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, 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.	

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