STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 May 2, 2016 and completed on May 5, 2016, the sample included three (3) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		6/9/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 156	Continued From page 2 the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the correct telephone number for the State Ombudsman Program for 12 of 12 sampled residents/resident representatives (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, and #12). Failure to provide this information has the potential to limit residents' and their families' access to this agency. Findings include: Observation on May 02-04, 2016, showed the facility's display board failed to list the correct phone number for the North Dakota Ombudsman Program. During an interview on 04/04/16 at 5:10 p.m., an administrative staff member (#2) confirmed the facility posted the incorrect phone number for the	F 156	1.)a.)5/4/16 Ombudsman Office number was verified. b.)All telephone numbers of pertinent state client advocacy verified. c.)Corrections made to state client advocacy posting and re-posted. 2.) All facility residents have the potential to be affected by this practice. 3.) a.)Post state client advocacy office numbers not the individuals name or phone number. b.)5/25/16 Office staff education to Good Samaritan Society Policy and Procedure Posting Information for the Resident, Resident Rights and SOM F156	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 156	Continued From page 3 North Dakota Ombudsman Program.	F 156	for posting state client advocacy office numbers. 4.) a.) Office staff will monitor monthly for one year for changes in the state client advocacy office numbers. b.)Quality Assurance Performance Improvement committee will review for compliance and to make recommendation as needed. 5.) Date of Correction or before 6/9/16	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the most recent Life Safety Code survey results were available for examination for 12 of 12 sampled residents/resident representatives (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, and #12). Failure to ensure the results of the surveys are available to residents is an infringement of their	F 167	1.) 5/4/16 Life Safety Code Survey conducted 3/1/16 placed in survey binder. 2.) All residents have the potential to be affected by this practice 3.) a.)5/24/16 Office staff educated to Resident Rights and SOM F167.	6/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 167	Continued From page 4 rights. Findings include: Observations on May 02-04, 2016 showed a binder contained the most recent Health survey results but failed to contain the results of the Life Safety Code survey, conducted on 03/01/16. During an interview on 05/04/16 at 3:54 p.m., an administrative staff member (#2) confirmed the binder did not contain the results of the Life Safety Code survey.	F 167	b.) Upon the facility's receipt of the state letter approving the Plan of Correction - the letter and survey will be placed immediately in the survey binder. 4.) a.)Office staff to monitor for the receipt of the state letter approving POC to be placed in binder immediately and audit upon each occurrence. b.)Quality Assurance Performance Improvement committee will review for compliance and make recommendation as needed. 5.) Date of Correction 6/9/16	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278		6/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 278	Continued From page 5 $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. 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 3.0), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the resident's status for 5 of 12 sampled residents (Resident #1, #3, #4, #6, and #9), and for 1 of 2 closed records reviewed (Resident #14). Failure to accurately complete portions of the MDS, Section M (Skin Conditions) (Resident #1, #3, #4, #6, #9, and #14) and Section E (Behaviors) (Resident #3), does not allow each resident's assessment to reflect the resident's current status/needs; and has the potential to affect the accurate development of a comprehensive care plan and to affect the care provided to all residents. Findings include: TURNING/REPOSITIONING The Long-Term Care Facility RAI User's Manual, October 2015, Page M-38, stated, "Definitions: Turning/Repositioning Program: Includes a	F 278	1.) A.)Resident #1, 6, 9 will have section M (skin conditions) modified to reflect accurate coding on the last MDS. B.)Resident #3 will have section M (skin) and E0100B modified to reflect accurate coding on the last MDS. C,)Resident #4 will have section M (skin) and M1200D (nutrition) modified to reflect accurate coding on the last MDS. 2.) A.) All residents who are identified at risk for pressure sores will have the MDS evaluated for accuracy in Section M (M1200C) and nutrition (M1200D) prior to submission by this practice. B.) All resident who are identified with behaviors will have the MDS evaluated for accuracy of Section E0100B prior to submission by this practice. 3.) A.) The facility will ensure that the MDS section M (skin), E0100b, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 278	Continued From page 6 consistent program for changing the resident's position and realigning the body. 'Program' is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs. . . . The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours). . . ." - Review of Resident #1's medical record occurred on all days of survey. A quarterly MDS, dated 02/25/16, identified a turning and repositioning program. The medical record lacked an individualized turning and repositioning program. - Review of Resident #3's medical record occurred on all days of survey. The significant change MDSs, dated 07/06/15, and 09/30/15, and a quarterly MDS, dated 03/15/16, identified a turning and repositioning program. The medical record lacked an individualized turning and repositioning program. - Review of Resident #4's medical record occurred on all days of survey. The quarterly MDS, dated 11/25/15 and the significant change MDS, dated 02/24/16, identified a turning and repositioning program. The medical record lacked an individualized turning and repositioning program. - Review of Resident #6's medical record occurred on all days of survey. A significant change MDS, dated 03/15/16, a turning and	F 278	M1200D (nutrition) sections are coded accurately and have proper backup documentation in the electronic record. B.) The MDS Coordinators and DON have been in-serviced regarding the RAI definitions for coding and proper documentation needed for individualized programs in section M1200C (turning) , E0100B, and M1200D (nutrition) on 5/25/16 by reviewing RAI section M-M1200C, M1200D on pages M38-42, and section E-EO100B on pages E1-4. 4.) A.) The MDS Coordinators or designee will audit to assure all MDS are coded correct in section M1200C (turning), Section E0100B; and M1200D (nutrition) prior to submission weekly for one month, monthly for three months, and then quarterly thereafter for one year. B.)Results will be immediately reported to the DON if concerns are identified, and immediate corrective action will be implemented. C.)The MDS coordinators or designee will submit a report of the monitoring results to the DON and she will submit to the QA Committee at each scheduled meeting. 5.) Date of compliance on or before 6/9/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 278	Continued From page 7	F 278		

repositioning program. The current care plan and the resident's medical record lacked an individualized turning and repositioning program.

- Review of Resident #9's medical record occurred on May 04-05, 2016. The admission MDS, dated 04/04/16, identified a turning and repositioning program. The medical record lacked an individualized turning and repositioning program.

- Review of Resident #14 medical record occurred on May 05-06 2016. A quarterly MDS, dated 11/16/15, identified a turning and repositioning program. The medical record lacked an individualized turning and repositioning program.

During an interview on 05/03/16 at 10:45 a.m. an administrative nurse (#5) confirmed the resident's turning and repositioning programs were not individualized.

NUTRITION OR HYDRATION INTERVENTIONS TO MANAGE SKIN PROBLEMS

The Long-Term Care Facility RAI User's Manual, October 2015, Page M-38-39, stated, ". . . The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. . . . Additional supplementation above the US RDI [recommended daily intake] has not been proven to provide any further benefits for management of skin problems . . . If it is determined that nutritional supplementation, i.e. adding additional protein, calories, or nutrients is warranted, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 278	Continued From page 8	F 278		

facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and tailor nutritional supplementation to the individual's intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed . . . "

- Review of Resident #4's medical record occurred on all days of survey. The significant change MDS, dated 02/24/16, identified nutrition or hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for the interventions for the purpose of preventing or treating specific skin conditions.

During an interview on 05/05/16 at 9:18 a.m. an administrative nurse (#6) confirmed the medical records lacked an individualized nutritional assessment.

BEHAVIORS

Review of the Long-Term Care Facility RAI User's Manual Version 3.0, revised October 2015, pages E-1-E-2 stated, "Delusion: A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary. . . . When a resident expresses a clearly false belief, determine if it can be readily corrected by a simple explanation of verifiable (real) facts (which may only require a simple reminder or reorientation) or demonstration of evidence to the contrary. . . . Check E0100B, delusions: if delusions were present in the last 7 days. . . ."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 278	Continued From page 9 - Review of Resident #3's medical record occurred on all days of survey. The significant change MDS, dated 09/30/15, identified the resident experienced delusions during the assessment period. The medical record lacked evidence to support the coding of delusions on the MDS. During an interview on 05/04/16 at 3:40 p.m. an administrative nurse (#5) confirmed Resident #3's medical record lacked evidence to support the coding of delusions on the MDS.	F 278		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 of 6 sampled residents (Resident #6) observed transferred with a sit-to-stand lift. Failure to have adequate staff assistance using a sit-to-stand lift transfer placed the resident at risk for sustaining a fall or injury. Findings include:	F 323	1.) Resident #6 had a new mobilization UDA done and the care plan updated 5/17/16. 2.) All resident who transfer with the sit-to-stand will have the potential to be affected by this practice. 3.) A.) Certified nursing assistants will be in-serviced regarding procedure for proper transfers with sit-to-stand including readjusting the safety belt and correct # of	6/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 10 Review of the facility policy titled "Mobility Support and Positioning: Mobility" occurred on 05/05/16. This policy revised in May 2016, stated, " . . . Purpose: . . . To support the resident's ability to move from . . . bed to chair using . . . positioning devices, sit-to-stand or stand aids. . . . Procedure: Surface to Surface with Sit-To- Stand: 1. Check kiosk [computer] prior to transfer for type of equipment to be used, harness size and amount of assistance required. . . . 19. Recheck the harness placement and adjust the safety belt as needed. When rising to a standing position, the safety belt will not fit as snugly as when the resident is seated and the belt may need to be tightened. . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia and left hip pain. The current care plan stated, ". . . Focus: The resident has an ADL [activity of daily living] self care performance deficit R/T [related to] mobility/cognitive impairment E/B [evidenced by] needing supportive assist with all cares. . . . Transfer: Use sit-to-stand lift . . . for all transfers with 1 staff members. [sic]" Review of Resident #6's Mobilization Support Data Collection Tool completed on 03/08/16, 03/09/16, and 03/14/16 stated, " . . . Transfers Between Surfaces: Leg Strength . . . 2. In a seated position, can the resident place hands on either side of the body and push off or rise off the surface 1 to 2 inches and sit down again? b. No, use sit-to-stand 2b. Number of to assist b) 2 . . ." Observation on 05/02/16 at 4:32 p.m. showed one certified nursing assistant (CNA) (#4)	F 323	staff used according to care plan. B.)All residents who use the sit-to-stand will have documentation audited to see that the Mobilization UDA matches the care plan interventions. 4.) A.) DON or designee will audit sit-to-stand transfers by nursing assistants for belt tightening and correct number of staff-weekly for one month, monthly for three months, and then quarterly thereafter for one year. B.)DON will report results to QAPI committee at each scheduled mtg. C.)MDS Coordinators or designee will monitor care plans and Mobilization UDA□s to make sure information regarding number of staff matches: weekly x 1 month, monthly x 3 months and then quarterly thereafter for one year. D.)Results will be immediately reported to the DON if concerns are identified, and immediate corrective action will be implemented. E.)The MDS coordinators or designee will submit a report of the monitoring results to the DON and she will submit to the QAPI Committee at each scheduled meeting. 5.) Date of compliance on or before 6/9/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 11 assisted Resident #6 onto the toilet using the sit-to-stand lift. As the CNA (#4) raised the resident to a standing position, the CNA (#4) failed to readjust or tighten the safety belt. Upon lifting Resident #6 off of the toilet, the resident slid down in the safety harness and complained of back pain. The CNA (#4) transferred the resident into the wheelchair and Resident #6 stated, "Thank God, Thank God." Observation on 05/03/16 at 4:17 p.m. showed one CNA (#4) transferred Resident #6 on and off of the toilet using the sit-to-stand lift. Staff failed to utilize two staff members during the sit-to-stand transfer and tighten the safety belt when raising Resident #6 to a standing position. During an interview on 05/05/16 at 11:00 a.m. a supervisory nurse (#1) confirmed Resident #6 required two staff members for sit-to-stand transfer.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		6/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 371	Continued From page 12 Based on observation, review of the manufacturer recommendations, and staff interview, the facility failed to properly prepare the sanitizing solution per manufacturer's guidelines in 1 of 1 kitchen area. Failure to prepare the sanitizing solution according to manufacturer's guidelines may result in ineffective sanitization of food contact surfaces and dining room tables which could affect all residents and staff eating the food prepared in the facility's kitchen. Findings include: Review of the manufacturer recommendations "Ecolab Oasis 146 Multi-Quat Sanitizer" instruction sheet occurred on 05/05/16. This undated instruction sheet stated, " . . . No-Rinse Quat Sanitizer 150 - 400 ppm [parts per million] . . . Withdraw and tear off approximately 2 inches of the test paper from dispenser. Dip test paper for 10 seconds in test solution. Don't shake. . . ." During the kitchen tour on 05/04/16 at 3:40 p.m., an administrative dietary staff member (#6) tested the chemical level in a red sanitization bucket (used in food contact areas). This staff member dropped the strip into the bucket, waited a few seconds, retrieved the strip, and stated the chemical concentration level was not correct. The solution tested 0 to 150 ppm. A dietary staff member (#7) stated, she had not tested the chemical level and had used the solution to wipe off the counters. This dietary staff member (#7) indicated she did not routinely test the chemical level of the sanitization bucket she only checked it when staff changed the sanitizing solution bottle in the dispenser.	F 371	1.) Proper Dietary Chemical Sanitizing log placed in dish room next to test strips. Staff educated to proper sanitizing procedure. 2.) All facility residents have the potential to be affected by this practice. 3.) 5/25/16 Educated Dietary staff to Good Samaritan Society Policy and Procedure Dietary Chemical Sanitization and SOM F371, Proper Sanitizer Charting Instructions, Nutrition and Food Service Edge □ Know your Sanitizer with Test. 4.) a.)To ensure ongoing compliance audits will be completed by Dietary Director weekly for one month, monthly for three months, and then quarterly thereafter for one year. b.)Quality Assurance Performance Improvement committee will review audits for compliance and to make recommendation as needed. 5.) Date of Correction on or before 6/9/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 371	Continued From page 13 Review of the "Dietary Chemical Sanitizing Log" from April and May 1-3, 2016, identified the sanitizer range of 400-500 ppm on the April log and 500 ppm on the May log. The April and May chemical log identified staff checked the level one to two times a day and recorded levels at 500 ppm every time staff checked the chemical. During an interview on 05/05/16 at 8:45 a.m., an administrative dietary staff member (#6) confirmed staff are expected to check the concentration level of the Quat sanitizer every time the bucket is filled, and the Quat sanitization level needs to be 200-400 ppm.	F 371		
F 385 SS=F	483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide physician services for 12 of 12 sampled residents (Resident #1 - #12) and 4 of 4 supplemental residents (Resident #15, #16, #17, and #18). Failure to provide a physician to supervise the	F 385	1.) For Residents #1-12 were seen 6/3/16 by physician. For unidentified residents 15,16,17,18 (new admits) were seen by a physician by day 30. No residents admitted to this facility after 4/19/16. Primary Care Physician will	7/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 385	Continued From page 14 care for residents in the facility and a physician to assume care for new admissions to the facility may prevent the resident from achieving his/her highest quality of life and services. Findings include: Review of the facility policy titled "Physician Services" occurred on 05/05/16. This policy, dated September 2012, stated, ". . . Resident Care: Each resident will remain under the care of a physician. The resident will have the right to choose a personal attending physician. The center will ensure that the medical care of residents is supervised by an attending physician or another physician if the attending physician is unavailable. . . ." During the entrance conference at 11:00 a.m. on 05/02/16, an administrative staff member (#2) reported the physician, who was also the medical director at the facility ended his contract on 03/31/16. The staff member (#2) reported the facility secured a contract on 04/15/16 with a new medical director. The administrative staff member (#2) stated the facility is currently in the process of seeking an attending physician to provide care to the residents in the facility. Information received at the entrance conference at 11:00 a.m. on 05/02/16 showed the facility admitted Resident #15, #16, #17, and #18 in April 2016. These admissions occurred after the physician ended his contract on 03/31/16. During an interview at 12:25 p.m. on 05/02/16, an administrative nurse (#1) reported the physician assistant and the nurse practitioner come to the	F 385	begin seeing residents on July 8, 2016. 2.) All facility residents have the potential to be affected by this practice. 3.) 5/25/16 Office staff, DON and Unit Managers educated to Good Samaritan Society Policy and Procedure Physician Services and SOM F385. 4.) Quality Assurance Performance Improvement committee will verify physician is on site 7/8/16, that the physician holds a North Dakota license to practice in North Dakota and continued physician coverage for compliance and to make recommendation as needed. 5.) Date of Correction on or before 7/8/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 385	Continued From page 15 facility to complete the 30/60/90 day medication reviews. The staff member (#1) reported all the current residents are seen by the nurse practitioner or the physician assistant. Refer to F388.	F 385		
F 388 SS=E	483.40(c)(3)-(4) PERSONAL VISITS BY PHYSICIAN, ALTERNATE PA/NP Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide health care practitioner visits that alternate between a physician and a mid-level practitioner for 4 of 12 sampled residents (Resident #1, #3, #7, and #11). Failure to provide a physician to oversee residents' care by performing facility visits could place residents at risk of a declining medical condition or harm due to the lack of physician oversight. Findings include: Review of the facility policy titled "Physician	F 388	1.) Resident 1,3,7,11 - were seen by physician 6/3/16. No residents admitted to this facility after 4/19/16. Primary Care Physician will begin seeing residents on July 8, 2016. 2.) All residents have the potential to be affected by this practice. 3.) Office staff, DON and Unit Managers educated on or before 5/25/16 to the Good Samaritan Society Policy and Procedure "Physician Services and SOM F388.	7/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 388	Continued From page 16 Services" occurred on 05/05/16. This policy, dated September 2012, stated, ". . . Physician Visits: . . . The physician will do the initial visit personally but may have the option of alternating further required visits between personal visits and visits by a physician's assistant, nurse practitioner or state-licensed clinical nurse specialist. . . ." During the entrance conference at 11:00 a.m. on 05/02/16, an administrative staff member (#2) reported the physician at the facility ended his contract on 03/31/16. An administrative nurse (#1) stated, "I know we have had a problem with the every other physician visits" being completed. Review of Resident #1, #3, #7, and #11's medical record occurred during the survey. According to a list of dates provided by the administrative nurse (#1) on 05/05/16, the following residents should have been seen by the physician during the month listed and not the mid-level practitioner. * Resident #1, April 2016 * Resident #3, April 2016 * Resident #7, April 2016 * Resident #11, April, 2016	F 388	4.) Quality Assurance Performance Improvement committee will verify physician is on site 7/8/16, that the physician holds a North Dakota license to practice in North Dakota and continued physician coverage for compliance and to make recommendation as needed. 5.) Date of Correction or before 7/8/16	
F 389 SS=F	483.40(d) PHYSICIAN FOR EMERGENCY CARE, AVAILABLE 24HR The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide or	F 389	1.) For Resident #1-12 Trinity Health Hospital Emergency Services Director	6/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 389	Continued From page 17 arrange for the provision of physician services 24 hours a day in case of an emergency for 12 of 12 sampled residents (Resident #1 - #12). Failure of the facility to arrange for a physician to be on call for medical emergencies has the potential to affect the care provided to the residents in the facility. Findings include: Review of the facility policy titled "Physician Services" occurred on 05/05/16. This policy, dated September 2012, stated, ". . . Emergency Care: the center will provide or arrange for physician emergency coverage 24 hours a day. When a resident's attending physician or alternate physician cannot be reached, the physician-on-call or medical director will be contacted. . . ." During the entrance conference at 11:00 a.m. on 05/02/16, an administrative staff member (#2) reported the physician at the facility ended his contract on 03/31/16. During an interview at 12:25 p.m. on 05/02/16 when asked who covers "on call" for the facility, an administrative nurse (#1) stated, "the physician assistant [PA] covers call and comes to the facility weekly." During a telephone interview at 11:30 a.m. on 05/04/16, a PA (#3) stated, "I am not on call" for the facility. The PA reported, he is available 8:00 a.m. to 5:00 p.m. Monday through Friday, but he does not "cover call on evenings and weekends." During an interview at 5:40 p.m. on 05/04/16 with staff members (#1 and #2), the surveyor reported the PA stated he is not on call for the facility. The	F 389	has been contacted to ensure provision of physician services 24 hours a day in case of an emergency. Attending physician, will begin accepting emergency calls on July 1, 2016. 2.) All residents have the potential to be affected by this practice. 3.) All Licensed staff and Medical Director have been educated on 5-24-2016 on the procedure titled, "Emergency Care with a focus on the need to have a physician desifor emergency cover 24 hours perday. 4.) An audit was developed to monitor each residents physician visit to ensure compliance in this area any abnormal dates will be corrected upon discovery. DNS or designee is responsible for the completion of the audit. The audit will be completed weekly x 4 weeks, monthly x 2 months, then quarterly for one year. An audit report summary will be submitted to the QA meeting for further recommendations. 5.) Compliance on or before 6/9/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 389	Continued From page 18 staff members indicated they were unaware of the PA's position. On the morning of 05/05/16, an administrative nurse (#1) reported a nurse practitioner had agreed "to take call" for the facility and if unable to reach her, staff are to "call the emergency room [ER]." A nurse practitioner does not meet the requirement of physician coverage.	F 389		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the attending physician reviewed and acted upon the consulting pharmacist's report of irregularities identified on monthly Medication Regimen Reviews (MRR) for 2 of 12 sampled residents (Resident #3 and #8) reviewed. Failure to act upon the drug irregularities identified by the pharmacist may result in unnecessary medications. Findings include:	F 428	1.) Resident #3 and #8 will have the latest Consultant Pharmacist monthly medication regimen findings reviewed and signed by Physician (Medical Director)on 5/23/16. 2.) All residents have the potential to be affected by this practice. 3.) A. The facility will ensure all residents will have the Consulting Pharmacist findings reviewed and signed by the Physician (Medical Director).	6/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 19 Review of the facility policy titled "PSYCHOPHARMACOLOGICAL MEDICATIONS AND SEDATIVE/HYPNOTICS" occurred on 05/05/16. This policy, revised March 2015, stated, ". . . 3. Other Psychopharmacological Medications . . . b. Tapering is considered clinically contraindicated if . . . the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder . . ." - Review of Resident #8's medical record occurred on all days of survey. The MRR dated 10/19/15 identified alprazolam (antianxiety medication) was due for a gradual dose reduction. The MRR lacked evidence of a physician's review/recognition of the pharmacist's findings. - Review of Resident #3's medical record occurred on all days of survey. The MRR, completed on 08/24/15, identified Zyprexa was due for a gradual dose reduction. The MRR, completed on 02/08/16, identified Zyprexa and clomipramine were due for a gradual dose reduction. The MRR lacked evidence of a physician's review/recognition of the pharmacist's findings. During an interview on 05/04/16 at 5:10 p.m. an administrative nurse (#1) stated she was unaware the physician must act upon pharmacy reviews.	F 428	B. DON and Unit managers were educated on F-tag 428 5/25/16 regarding Physician needs to review and sign Consultant Pharmacist monthly reports and GDR. 4.) a.)The DON or designee will monitor the Consultant Pharmacist notes to ensure all residents medication drug regime is reviewed and signed by Primary physician or Medical Director monthly x 3 months, then quarterly thereafter for one year. b.)Results will be immediately reported to the Administrator if concerns are identified, and immediate corrective action will be implemented. c.) The DON or designee will submit a report of the monitoring results to the QAPI Committee at each scheduled meeting. 5.) Date of Correction on or before 6/9/16	
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		6/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 441 SS=D	Continued From page 20 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 441	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of daily maintenance instructions, and staff interview, the facility failed to follow accepted infection control practices for 1 of 2 resident whirlpool bathtub (bathtub on the short hallway running perpendicular to the South hallway) used. Failure to follow accepted infection control practices when disinfecting the whirlpool bathtub between residents has the potential to spread infection within the facility. Findings include: Review of the facility policy "Bathing" occurred on 05/05/16. This policy, revised May 2016, stated, ". . . PROCEDURE FOR CLEANING TUB AND SHOWER STALL . . . 2. Spray walls of tub or shower stall with disinfectant and brush across surfaces. Allow disinfectant to remain on surfaces for at least 10 minutes or according to manufacturer's recommendations. . . ." Review of the "PENNER PATIENT CARE Whirlpool Disinfectant Cleaner" manufacturer recommendations occurred on 05/05/16. The directions for use stated, " . . . After using the whirlpool unit, drain and refill with fresh water to just cover the intake valve. Add 2 ounces of Penner Patient Care Whirlpool Disinfectant Cleaner for each gallon of fresh water added. . . . Treated surfaces must remain wet for 10 minutes. . . ." - Observation on 05/03/16 at 10:15 a.m. showed a CNA (#9) in the bathing area. The CNA	F 441	1.) The tub will be disinfected for 10 min. by CNA's. 2.) All residents who bathe have the potential to be affected. 3.) a.) The procedure for Disinfecting the Penner tub was updated on 5/15/16. b.) Bath aides and nursing assistants will be in-serviced regarding the updated procedure b/w 5/15/16 to 5/20/16. 4.) a.)The Bath aides or DON will audit tub disinfection weekly x one month, monthly for 3 months, and quarterly thereafter for one year. b.)Results will be immediately reported to the DON if concerns are identified, and immediate corrective action will be implemented. c.)The DON or designee will submit a report of the monitoring results to the QAPI Committee at each scheduled meeting. 5.) Date of correction on or before 6/9/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 441	Continued From page 22 explained she disinfects the bathtub between residents by using the disinfecting jets. She then uses a brush to scrub the entire bathtub and rinses off the disinfectant solution after three to four minutes. - Observation on 05/05/16 at 9:30 a.m. showed a CNA (#10) in the bathing area. The CNA explained she disinfects the bathtub between residents by using the disinfecting jets. She then uses a brush to scrub the entire bathtub and rinses off the disinfectant solution after five minutes. During an interview on 05/05/16 at 10:20 a.m. an administrative nurse (#1) confirmed she expects staff to leave the disinfectant solution on the tub surfaces for 10 minutes.	F 441		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and staff interview, the facility failed to maintain a functioning call system for 10 of 14 resident rooms (Room 506, 510, 512, 516, 518, 522, 601, 605, 609, and 613) on the South unit for approximately 10.5 hours. Failure to have a functional call system may lead to falls, accidents, injuries, and residents not receiving assistance when needed.	F 463	1.) Resident rooms 506, 510, 512, 516, 518, 522, 601,605, 609, and 613 have had the call light fixed as of 5/11/16. 2.) All resident rooms have the potential to be affected by this practice. 3.) A. The facility will ensure that all residents have an alternate method to call	6/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 463	Continued From page 23 Findings include: Review of the facility policy titled "CALL LIGHT" occurred on 05/05/16. This policy, dated September 2012, stated, "PURPOSE To ensure resident always has a method of calling for assistance . . ." Review of the facility procedure titled "CALL LIGHTS NOT WORKING IN THE FACILITY" occurred on 05/05/16. This undated policy, stated, "If it is found that the call lights are not working in the Resident Rooms, the following procedure will be implemented: 1. Immediately call the MAINTENANCE SUPERVISOR OR MAINTENANCE PERSON. 2. Those Residents who need close monitoring because of physical condition will be identified by the Charge Nurse and checked on every 15 minutes. 3. The remaining Residents will be checked every hour. 4. This procedure will continue until the System is operating properly. 5. Bed check alarms should always be connected to the 'RED' emergency power outlet in the Resident rooms. The call cord will remain connected this allows the bed check to alarm even when the call light system is down." During an interview on 05/02/16 at 4:45 p.m., an administrative staff member (#2) stated the call lights on the south side of the south unit stopped working on 04/11/16 and started functioning 04/14/16. Facility staff initiated whistles and bells on 04/12/16 at 8:00 a.m. During an interview on 05/03/16 at 8:05 a.m., an administrative staff member (#2) stated the call	F 463	for help if a call light outage occurs. B. Procedure for Call light Outage was updated 5/11/16 and a Call Light Outage kit was developed 5/11/16. C. All employees in attendance at the All staff meeting were educated in the updated Call Light Outage Procedure and Call Light Outage Kit on 5/11/16. C. a) Quarterly staff educational sessions regarding the new procedure will be held x 1 year and PRN thereafter. D. Nursing department staff will be educated 5/15/16 thru 5/20/16 regarding the updated procedure and the Call Light Outage kit. 4.) A.) The Charge Nurse, Administrator, or DON will audit any outages when they occur to assure the procedure and kit is used when there is a Call Light Outage occurrence. B.) Results will be immediately reported to the Administrator if concerns are identified, and immediate corrective action will be implemented. C.) The DON or Administrator will submit a report of the monitoring results to the QAPI Committee at each scheduled meeting. 5.) Date of completion on or before 6/9/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/05/2016

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 463	Continued From page 24 lights on the south side of the south unit stopped working on 04/11/16 at 9:30 p.m. During an interview on 05/03/16 at 9:45 a.m. an administrative nurse (#1) stated facility staff initiated the procedure on 04/11/16 when the call lights stopped working and they frequently checked on high risk residents. The administrative nurse (#1) confirmed the facility lacked evidence of the frequent checks. The facility failed to provide a method for residents to call for assistance for 10.5 hours.	F 463		