STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355099	A. BUILDING _____ B. WING _____	05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOTT	401 MILLIONAIRE AVE MOTT, ND 58646

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on May 19, 2014 and completed on May 21, 2014, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included three (3) additional residents to verify specific concerns during the survey.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. 1) Since the window of time to ensure proper investigation and notification is past for Resident #1, the corrective action is that the incident investigative team (ADM, DNS, SW) is aware of the oversight and the resident's record was reviewed by the team to determine what thorough investigation and reporting should have occurred.	06/20/14

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tracee O. Kelly — TITLE: Administrator — (X6) DATE: 6/18/14

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to implement established policies and procedures to thoroughly investigate and report possible violations, including injuries of unknown origin for 1 of 1 sampled resident (Resident #1) identified with multiple fractures. Failure to report and investigate injuries of unknown origin placed this resident and other residents at risk for mistreatment and/or abuse, and did not allow the facility to determine causative factors for the injury and implement corrective action. Findings include: Review of the American Academy of Orthopaedic Surgeons "OrthoInfo - Tibia (Shinbone) Shaft Fractures," orthoinfo.aaos.org, copyright 1995-2014, stated, ". . . The long bones include the femur, humerus. . . . Spiral fracture: This type of fracture is caused by a twisting force. The result is a spiral-shaped fracture line about the bone, like a staircase. . . . Because it typically takes a major force to break a long bone, other injuries often occur with these types of fractures."	F 225	2) The facility recognizes that all residents in the facility have the potential to be affected by the same practice. Investigative team reviewed all residents on 6/16/14 and find that there are no residents affected at this time. 3) Measures put into place to ensure the practice will not recur is that the investigative team will review all resident incident reports on a daily basis to determine if there is investigation and reporting required. Investigative team will also inquire at daily report if incident report was done on incidents discussed and that causative factors were determined. Nursing staff was educated on 6/17/14, using the facility policy and procedures on abuse/neglect and incident reporting. The review focused on a) Procedure for abuse and neglect and b) Policy for resident incident reports. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that all incidents of unknown origin were appropriately investigated and if causative factors are not determined, if incident was reported to the state health department. These audits will be done daily x 1 week, monthly x 3 and quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 225	Continued From page 2 Review of the facility policy/procedure titled "Abuse and Neglect" occurred on 05/21/14. This policy, revised October 2009, stated, ". . . Alleged or suspected violations involving any mistreatment, neglect or abuse including injuries of unknown origin will be reported immediately to the center administrator and to other officials in accordance with state law, including the state survey and certification agency. . . . The center will have evidence that all alleged or suspected violations are thoroughly investigated . . . Results of all investigations will be reported . . . including to the state survey and certification agency within five working days of the incident . . . "PURPOSE: . . . *To ensure that all identified incidents of alleged or suspected abuse/neglect are promptly investigated and reported *To ensure that all identified incidents involving injuries of unknown origin are promptly investigated to determine probable cause of unknown origin injuries . . . *To ensure that a complete review of existing incidents is documented *To identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse and to determine the direction of the investigation . . ." Review of the facility policy titled "Resident/Visitor Incident Report" occurred on 05/21/14. This policy, revised January 2009, stated, ". . . All incidents/occurrences occurring within the center or affecting a resident/visitor will be documented, investigated and evaluated to determine contributing factors and to prevent recurrence whenever possible. . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia, traumatic right hip fracture with	F 225		

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F 225	Continued From page 3 surgical repair (November 2013), osteoporosis, arthritis, and fracture of right and left humerus (December 2013). Review of Resident #1's nursing progress note, dated 12/04/13 at 9:30 a.m., indicated the resident was transported via van to the clinic for an x-ray. Review of Resident #1's hospital history and physical, dated 12/04/13, stated, "The patient was transferred from [clinic] today . . . the ambulance crew noted that she complained of some left arm pain, and when she got here and was transferred to the floor as a direct admit, the nurses noticed that she had deformity of both of her arms . . . ." Review of Resident #1's hospital consulting physician's report, dated 12/04/13, stated, ". . . Today she was being hoist [sic] up in a lift [at the nursing home], which was a standing type of lift . . . had some left humerus area pain and it was noted that there was swelling and tenderness of the mid left humerus. she also has an ecchymosis [bruise] just inferior to her right shoulder joint. . . ." Review of Resident #1's hospital radiology reports, dated 12/04/13, stated, * ". . . Spiral fracture of the right humeral. . . ." * ". . . Spiral fracture involving the left humerus. . . ." During interviews, on 05/21/14 at 7:55 a.m. and 12:20 p.m., a nurse manager (#2) verified: * Staff failed to complete an incident report pertaining to Resident #1's multiple injuries. * The facility failed to investigate possible causes for Resident #1's multiple injuries.	F 225		

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F 225	Continued From page 4 * Staff failed to report to the State Agency. During an interview, on 05/21/14 at 1:20 p.m., a nursing staff member (#1 confirmed she failed to complete an incident report. Failure to report, document, and investigate these injuries placed Resident #1 at risk for mistreatment and/or neglect, and did not allow the facility to determine causative factors for the injuries and implement corrective action.	F 225		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE 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, the facility failed to provide medically-related social services for 1 of 1 sampled resident (Resident #2) who threatened to kill herself. Failure to address the psychosocial needs of Resident #2 and implement interventions related to these needs may be detrimental to the resident's psychological and mental well-being and may negatively affect her overall level of functioning. Findings included: Review of Resident #2's medical record occurred on all days of survey. Diagnoses included psychosis, depression, and anxiety. A quarterly	F 250	1)-The corrective action accomplished for Resident #2 to ensure that medically related social services are provided and that the highest practicable psychosocial well-being is attained or maintained is that Social Services visited with Resident #2 on 6/16/14 to determine what interventions need to be in place when resident indicates that conditions exist that are detrimental to the resident's mental well-being. Appropriate documentation has been done and care plan was updated. 2) Other residents having the potential to be affected by the same practice have been identified by the Social Services Coordinator querying MDS 3.0, D00200 I #1, relating to resident mood and behaviors, requiring a "yes" answer to that indicator. Social Services coordinator followed up with other residents identified using the facility's procedure for suicide precautions. 3) Measures put into place to ensure the practice will not recur is that all staff have been educated by DNS on 6/17/14 on the	06/20/14

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F 250	Continued From page 5 Minimum Data Set (MDS), dated 02/26/2014, identified Resident #2 with intact cognition, feeling down, depressed, hopeless, tired, and having little energy nearly every day. Current scheduled medications included BuSpar 20 milligrams (mg) daily for anxiety, Klonopin 1 mg daily for anxiety, and Seroquel 50 mg at bedtime and 25 mg three times daily for unspecified psychosis. As needed (PRN) medications included Xanax .25 mg twice daily for anxiety. The admission Minimum Data Set, dated 09/03/13, indicated the presence of "Thoughts that you would be better off dead, or of hurting yourself in some way" occurred nearly every day during the assessment period. The current care plan, identified the following focus and interventions initiated on 11/29/13, "Focus . . . The resident has depression and receives an antidepressant medication daily. . . . Interventions . . . Monitor/record/report to health care provider PRN risk for harm to self; suicidal plan, past attempt at suicide, risky actions to intentionally harm or try to harm self . . . sense of hopelessness or helplessness, impaired judgment or safety awareness." The progress notes, dated 03/12/14 at 12:30 a.m., identified staff administered PRN Xanax .25 mg for "Talking about suicide and how to do it." At 5:04 a.m. documentation indicated the resident was "Sleeping." No further documentation was noted regarding the resident's suicide statement. A mental health progress note, dated 03/19/14, failed to address the statements of self harm made by Resident #2.	F 250	guidelines for understanding and helping the suicidal resident. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits for appropriate interventions on residents with suicidal thoughts. These audits will be done monthly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 278 SS=D	Continued From page 6 483.20(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 $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 Set (MDS) accurately reflected the	F 278 F 278	1)The corrective action accomplished for Resident #7 found to have been affected by accurate coding of resident's status is that a modification of the admission MDS (12/19/13) and the quarterly MDS (3/2/14) was completed on 6/17/14 by MDS coordinator to accurately reflect proper coding was completed. 2) Other residents having the potential to be affected by the same practice have been identified by licensed nursing staff querying MDS 3.0, section E0100 A & B. Residents identified with psychosis will have individualized care plans consistent with their needs and functional status. 3) Measures put into place to ensure the practice will not recur is that the MDS coordinator/RN educated the MDS team on 6/17/14, addressing proper coding and documentation to support accurate coding of the MDS. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that the MDS is accurately coded with appropriate documentation. These audits will be completed monthly x 3 months and quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	06/20/14

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F 278	Continued From page 7 resident's status for 1 of 1 sampled resident (Resident #7) coded with hallucinations and delusions. Failure to accurately code the MDSs for these residents limited the facility's ability to develop and implement individualized care plans consistent with their needs and functional status and may affect the level of care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual (Version 3.0), October 2013, pages E-2 - E-3 stated, ". . . E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply. *Check E0100A, hallucinations: if hallucinations were present in the last 7 days. A hallucination is the perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch. *Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. *Check E0100Z, none of the above: if no hallucinations or delusions were present in the last 7 days . . . Coding Tips and Special Populations, *If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, do not code it as a delusion. *If a resident expresses a false belief but easily accepts a reasonable alternative explanation, do not code it as a delusion. If the resident continues to insist that the belief is correct despite an explanation or direct evidence to the contrary, code as a delusion. . . ."	F 278		

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F 278	Continued From page 8 - Review of Resident #7's medical record occurred on May 21, 2014. Diagnoses included dementia, depression, unspecified paranoid state, and anxiety state. The admission MDS, dated 12/09/13, identified the resident experienced hallucinations and delusions during the look back period. A quarterly MDS, dated 03/02/14, identified the resident experienced delusions during the look back period. Resident #7's medical record lacked evidence to support the coding of hallucinations on the admission MDS, and the coding of delusions on both MDSs. During an interview on the afternoon of 05/21/14, a staff member (#4) who completes section E confirmed the documentation failed to identify hallucinations or delusions occurred during the look back period.	F 278		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: TRANSFERS/PAIN 1. Based on record review, review of professional literature, and staff interview, the facility failed to ensure residents were transferred using appropriate equipment and proper techniques for	F 309		

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 9 1 of 1 resident (Resident #1) who experienced right hip pain during a stand lift transfer, later identified as a spiral fracture with additional spiral fractures to both upper arms. Facility staff transferred the resident for x-rays via wheelchair van after observing signs/symptoms of a possible hip fracture. This resulted in Resident #1 experiencing increased pain which required additional pain medications, increased need for assistance with activities of daily living (ADL), and a decline in her overall quality of life. Findings include: Review of the American Academy of Orthopaedic Surgeons "OrthoInfo - Tibia (Shinbone) Shaft Fractures," orthoinfo.aaos.org, copyright 1995-2014, stated, ". . . The long bones include the femur, humerus. . . . Spiral fracture: This type of fracture is caused by a twisting force. The result is a spiral-shaped fracture line about the bone, like a staircase. . . . Because it typically takes a major force to break a long bone, other injuries often occur with these types of fractures." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia, traumatic right hip fracture with surgical repair (November 2013), osteoporosis, arthritis, and the identification of a right hip spiral fracture and spiral fractures of both upper arms on 12/04/13. The admission Minimum Data Set (MDS), dated 12/02/13, identified the resident required extensive assistance from two or more people for bed mobility, transfers, toileting, dressing and independent with setup help only for eating. A quarterly MDS, dated 12/12/13, and a quarterly MDS, dated 03/06/14, identified Resident #1 now required total assistance from	F 309	1) The corrective action accomplished for Resident #1 related to providing resident transfers with appropriate equipment and proper techniques is that nursing staff was instructed by the DNS on 6/17/14 to call physician for order for type of transfer when a resident is suspected to have a lower extremity fracture. The corrective action accomplished for Residents #4 and #6 related to providing services to manage pain and symptoms of anxiety and identifying causative factors for pain, implement individualized interventions and accurate monitoring of anxiety and pain is that these two residents have had an updated pain data assessment completed and individualized non-pharmacological interventions identified with care plans updated on 6/18/14. 2) Other residents having the potential to be affected by the same practice have been identified by querying MDS 3.0 sections J0300 #1 and E0500 with the answer yes. Residents will also be identified in a monthly Behavior Management Meeting. Residents have the potential for inappropriate transfers will be identified in monthly risk Management Meetings. Residents at high risk for pain or exhibiting high behavior problems will be reviewed on weekly basis for appropriate management by DNS or designee. Any non-effective treatment will be referred to primary physician.	06/20/14

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F 309	Continued From page 10 two or more people for bed mobility, transfers, toileting, and dressing and total assistance of one for eating. The respective MDSs identified Resident #1 declined from moderate cognitive impairment on 12/02/13 to severe cognitive impairment on 12/12/13 and 03/16/14. A "TRANSFER LIFT ASSESSMENT FOR RESIDENTS," completed the day of Resident #1's admission to the facility on 11/27/13 showed a nursing staff member assessed the resident for transfer ability and determined a sit-to-stand lift would be safest. A Physical Therapy (PT) note written the day after Resident #1's admission to the facility on 11/27/13, stated, "Patient is back from [hospital] after a total hip, she is weight bearing as tolerated. . . bed mobility with mod [moderate] assist of two, transfers with mod assist of two, patient not able to stand or initiate gait training . . . did advise staff to use the EZ lift [stand lift] and make sure that they put shoes on her feet so that her feet don't slip on the ground or the lift, . . ." Resident #1's Physical Therapy Evaluation and Plan of Treatment, dated 12/02/13, indicated: * a primary diagnosis of right hip fracture * right and left upper extremity range of motion (ROM) was within functional limitations (WFL) * bilateral upper extremity strength four (five being the strongest) * pain in the right hip * ". . . Patient seen today for 25 minute treatment . . . Upper and lower extremity active and active assistive ROM were performed . . . weight bearing as tolerated on the right lower extremity. . . "	F 309	3) Measures put into place to ensure the practice will not recur is that nursing staff was educated by the facility's DNS on 6/17/14 on proper completion of pain data collection, pain assessments and care plan updates. Nursing staff also received education by DNS on non-pharmacological interventions as well as giving pain medications first and after one hour if non-effective, you may then attempt anti-anxiety medications as ordered. In addition the pharmacy review committee will review and monitor the effectiveness and use of unnecessary medications along with behavior committee will monitor the effectiveness of non-pharmacological interventions and use of antipsychotics for behaviors on a monthly basis. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator or designee to use audits to monitor completion of pain assessments, individualized care plans and the use and effectiveness of non-pharmacological interventions, along with assuring that pharmacy and behavior meetings are being conducted Audits will also be done on incident reports to assure that appropriate transfers were done on residents with injury. Audits will be done monthly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 309	Continued From page 11 A PT note, dated 12/04/13, stated, "patient has again fractured the same hip . . . discharged from Physical Therapy . . ." Review of Resident #1's late entry progress note, dated 12/04/13 at 6:30 a.m., stated, "When cna [certified nursing assistant] assisting with AM [morning] care res. [resident] c/o [complained of] pain (R) [right] hip et [and] leg, hollaring [sic] out. Extremity is rotated out, swelling note (R) knee et upper thigh. Leg is shorter than (L) [left] leg. Medicated with prn [as needed] Ultram. Will keep in bed at this time. [Resident's physician] will be in facility this AM, et will have him look at." At 9:05 a.m., the resident's physician requested an x-ray, and at 9:30 a.m., the resident was transported via the facility's wheelchair van to the clinic. Review of Resident #1's hospital history and physical, dated 12/04/13, stated, "The patient was transferred from [clinic] today. Apparently she was in the [nursing home] . . . a pop or a snap was heard and she had immediate pain in her right hip . . . the ambulance crew noted that she complained of some left arm pain, and when she got here and was transferred to the floor as a direct admit, the nurses noticed that she had deformity of both of her arms . . . ." Review of Resident #1's hospital consulting physician's report, dated 12/04/13, stated, ". . . Today she was being hoist [sic] up in a lift, which was a standing type of lift and a popping sound was appreciated by the nursing home staff and she did seem to have right hip pain after that and also had some left humerus area pain and it was noted that there was swelling and tenderness of the mid left humerus. She also has an ecchymosis [bruise] just inferior to her right	F 309		

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F 309	Continued From page 12 shoulder joint. . . ." Review of Resident #1's hospital radiology reports, dated 12/04/13, stated, * ". . . Acute, spiral fracture of the subtrochanteric right femur. . . ." * ". . . Spiral fracture of the right humeral. . . ." * ". . . Spiral fracture involving the left humerus. . . ." Discharge orders from an acute care hospital stay, dated 12/06/13, stated a medical equipment supplier would come to the facility on 12/13/13 to place a brace to both upper arm (humerus) fractures. An internet website, http://ezinearticles.com/?Humeral-Fracture-Brace---Sarmiento-Style"states " A humeral fracture brace is provided to a patient to help provide support to their arm. Without something supporting a person's humerus after a fracture the pain will most likely escalate on a day to day basis. In addition, there is less of a chance that the fracture will heal properly." The facility faxed the resident's physician on 12/19/13 stating, "[Medical equipment supplier] can't come for 40 days to fit her [resident] for Seriento splints - What do you want us to do - She wouldn't tolerate trip to Bis [Bismarck] for this et [Medical equipment supplier] said she'd be healed B/4 [before] they get here." The physician's response, dated 12/19/13, stated, "Schedule bilat. [bilateral] humerus xrays in [medical facility], Jan. 3 with F/U [follow-up] appt. with [physician]." A delivery ticket identified the facility received the bilateral humerus splints on 01/07/14. The facility failed to obtain the bilateral humerus splints until a month after the order was written.	F 309		

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Review of Resident #1's December 2013 and January 2014 electronic medication administration record (EMAR) identified the following scheduled and as needed (PRN) pain medications:
* Tylenol 650 milligrams (mg) every 6 hours PRN started 11/26/13. (Order still in effect on the May 2014 EMAR).
* Tylenol 650 mg three times daily (tid) from 12/06/13 to 12/16/13
* Ultram 50 mg tid from 12/06/13 to 12/16/13
* Hydrocodone-Acetaminophen 10-325 mg every 4-6 hours PRN started 12/06/13. Administered 16 times in December 2013. (Order still in effect on the May 2014 EMAR to administer every 6 hours PRN).
* Hydrocodone-Acetaminophen 10-325 mg tid started on 12/16/13. (Order still in effect on the May 2014 EMAR).
* Morphine Sulfate Solution 2 mg Intramuscular every 2 hours PRN started on 12/28/13. Administered 18 times in January 2014.
* Morphine Sulfate Extended Release tablet 15 mg daily started on 12/31/13. Increased to twice daily (bid) on 01/03/14. (Order still in effect on the May 2014 EMAR).

During an interview on 05/21/14 at 12:20 p.m., a nurse manager (#2) verified:
* Staff transferred the resident via the facility's wheelchair van to the clinic for x-rays.
* Staff failed to complete an incident report and/or investigate possible causes for Resident #1's multiple injuries before or after transfer to the clinic.
* Staff had to be very careful when transferring Resident #1 with a full body lift after the 12/04/13 injuries. Any movement of the resident by staff

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was very painful.
* Staff used arm slings when the resident returned on 12/06/13 for her arm fractures until the arm splints arrived on 01/07/14.

During an interview, on 05/21/14 at 1:20 p.m., a nursing staff member (#1) verified a CNA stated the resident was in the stand lift when she heard the "pop." The nursing staff member (#1) confirmed staff placed the resident back into her bed until the physician arrived at the facility.

The medical record lacked evidence the facility evaluated and determined causative factors for Resident #1's multiple fractures obtained during a lift transfer in the facility. There is no evidence to indicate Resident #1 was transferred with two staff and that her shoes were on during the transfer, as per the resident's care plan. Transporting the resident in the facility van to the clinic after staff documented signs/symptoms of a possible hip fracture contributed to increased pain and may have caused further damage to the fractured limbs. Failure to ensure staff followed proper transfer procedures resulted in increased injury and/or caused the three fractures affecting three major bones. This resulted in Resident #1 experiencing severe pain requiring opioid analgesics, the need for increased help with ADLs, and a decrease in Resident #1's quality of life.
2. Based on observation, record review, and review of facility policy, the facility failed to provide the necessary care and services to manage pain and symptoms of anxiety for 2 of 2 sampled residents (Resident #4, and #6) with a diagnoses of anxiety and pain receiving as needed (PRN)psychopharmacological and pain medications. The failure to identify and assess

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F 309	Continued From page 15 the reason/causative factor(s) for pain, implement appropriate individualized interventions (including non-pharmacological interventions), and establish accurate on-going monitoring of the anxiety or pain has the potential for unnecessary use of medications, failure to manage pain, and may result avoidable agitation/anxiety. Findings include: Review of the facility policy titled "Pain Data Collection and Assessment" occurred on 05/21/14. This policy, revised August 2013, stated, "PURPOSE . . . *To determine what pain relief interventions that are specific to the resident that can be utilized and established to aid in maintaining a comfortable level of function and quality of life. NOTE: A pain management plan can include, but not be limited to, a medical regime. The analysis should help determine what other methods or alternatives of pain control/relief may be implemented before contacting a physician. The care team and nurses must continually monitor and evaluate the pain management plan. . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included anxiety state, pain, and a cerebral vascular accident (CVA) diagnosed in May 2014. An admission Minimum Data Set (MDS), dated 04/01/14, identified the resident as cognitively intact and experiencing occasional mild pain. During observations of staff transferring Resident #4 with a lift or repositioning her in bed on 05/19/14 at 1:10 p.m., 2:40 p.m., and 05/20/14 at 7:25 a.m., 9:50 a.m., and 2:30 p.m., the resident complained of pain in her right foot and leg.	F 309		

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F 309	Continued From page 16 A "Pain Data Collection" form, dated 05/07/14, indicated Resident #4's pain intensity was "Hurts a whole lot." Other indicators of pain identified were non-verbal sounds, facial expressions, and protective body movements. The form indicated Resident #4 received no scheduled medications for pain, received no non-medication interventions, but did receive PRN Tylenol the night before the assessment. Resident #4's current physician orders listed the following: *Alprazolam (an antianxiety medication) 0.25 mg every 6-8 hours as needed for anxiety *Acetaminophen 500 mg every 4-6 hours as needed for pain Review of Resident #4's PRN Medication Administration Record (MAR) for May 13-20, 2014, showed facility staff administered PRN Acetaminophen 4 times and PRN Alprazolam 10 times. The medications were administered together on two occasions. Review of Resident #4's current care plan failed to address sign and symptoms of pain that the resident may have experienced and failed to develop pain management interventions. Though the progress notes for May 13-20, 2014 indicated that when asked if she was having pain, the resident reported "I don't know," the above observations of cares on May 19 and 20, demonstrated the resident experienced pain in her right leg and foot causing increased anxiety. Facility staff administered an antianxiety medication and a pain medication at the same	F 309		

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F 309	Continued From page 17 time, which does not allow staff to determine if one medication alone would have been effective. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included anxiety state and pain. A quarterly Minimum Data Set (MDS) dated 02/24/14 identified the resident as having impaired cognition, and rarely experiencing pain effecting sleep and activities. During the assessment the resident indicated pain intensity as severe. A "Pain Data Collection" form, dated 02/24/14, indicated the following regarding Resident #6, "Pain effects on function, over the last five days, has pain made it hard for you to sleep? yes, . . . limited your day-to-day activities because of pain, yes, . . . concentration, decrease . . . relationship with others, Demonstrates agitation and restlessness at times, Pain management: Received non-medication interventions for pain? no, Received scheduled pain medication regimen? no, Received PRN pain medications or was offered and declined? yes specify "Tylenol 650 mg [milligrams] PRN." Resident #6's current physician's orders listed the following: *Ativan (an antianxiety medication) 0.5 mg by mouth "one time a day related to DEPRESSIVE DISORDER NOT ELSEWHERE CLASSIFIED GIVE FOR HOLLERING" * Ativan 0.5 mg orally every 6 hours as needed for Anxiety * Tylenol (acetaminophen) 650 mg orally every 6 hours as needed for Pain-Mild Review of Resident #6's PRN Medication Administration Record (MAR) showed the	F 309		

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F 309	Continued From page 18 following: *February 2014 - 8 doses of PRN Ativan and 12 doses of PRN Tylenol. Four times the two medications were administered together. *March 2014 - 5 doses of PRN Ativan and 4 doses of PRN Tylenol. One time the two medication were administered together. *April 2014 - 2 doses of PRN Ativan and 11 doses of PRN Tylenol. One time the two medications were administered together. *May 2014 - 9 doses of PRN Ativan and 3 doses of PRN Tylenol. One time the two medications were administered together. Review of Resident #6's progress notes from February through May 2014 indicated he complained of back, leg, and neck pain. A MDS note, dated 02/24/14, stated, ". . . Pain interview revealed resident voicing 'rare, severe' neck pain in the last 5 days that does interfere with sleep and daytime activity involvement. Resident does not receive any scheduled pain medication, but was given PRN Tylenol x [times] 3 in last 5 days . . ." Review of Resident #6's current care plan failed to address signs and symptoms of pain that the resident may have experienced and failed to develop pain management interventions. Facility staff administered an antianxiety medication and a pain medication at the same time to Resident #4 and Resident #6. This does not allow staff to adequately assess the effectiveness of one medication before administration of another medication.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	Continued From page 19 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to monitor and assess for potential side effects and adequate indications for use of an antipsychotic, anti-anxiety, and/or pain medications for 3 of 3 sampled residents (Resident #2, #3, and #7) receiving medications to control behavior and/or pain without evidence of attempts by the facility to minimize the behavior or pain through effective non-pharmacological interventions. Failure to	F 329	1) The corrective action accomplished for Residents #2, #3 and #7 related to each resident's drug regimen free from unnecessary drugs is that pain assessments have been completed on 6/18/14 and interventions including non-pharmacological interventions have been implemented with care plans updated. Although an initial involuntary movement test could no longer be done on resident #7, an AIMS assessment was completed on 5/21/14 with no problems noted. 2) Other residents having the potential to be affected by the same practice have been identified by querying MDS 3.0 section E0300 #1 along with identifying residents with behaviors in a behavior meeting. All residents displaying behaviors will have a pain assessment completed by 6/20/14 to determine the need for an individualized pain management program along with the behavior meetings determining behavior interventions and that residents receiving antipsychotics will have timely AIMS testing done by running Order Listing Report to determine the residents receiving anti-psychotics. 3) Measures put into place to ensure the practice will not recur is that nursing staff was educated by the facility's DNS on 6/17/14 on appropriate pain assessments and non-pharmacological interventions for behaviors before administering anti-psychotics. Pain medications should be	06/20/14

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F 329	Continued From page 20 thoroughly assess and document the residents' behaviors and pain, implement individualized interventions, including non-pharmacological interventions, and establish on-going monitoring of the behaviors and pain has the potential for decreased physical, mental, and psychosocial well-being and may negatively impact the residents' quality of life. Findings include: Review of the facility procedure titled, "Psychopharmacological Medications and Sedative/Hypnotics" occurred on 05/21/14. This policy, dated September 2013, stated, "Purpose: To evaluate behavior interventions and alternatives before using psychopharmacological medications and sedative/hypnotics. To eliminate unnecessary psychopharmacological medications and sedative/hypnotics. Procedure: Non-Emergency Administration 1. Prior to administration of non-emergency psychopharmacological and/or sedative/hypnotics, the following must be completed: a. Documentation in the Hands On application or in the medical record observations of mood symptoms or behaviors that cause the resident distress and/or endangers the resident or others and response to interventions used. b. The behavior committee and/or care plan team will ensure the care plan is updated. This update will reflect non-pharmacological interventions to be used. . . . 3. If the reduction committee determines that medication is warranted, then the committee nurse will ensure the following is completed: a. Contact the physician and describe the behavior, attempted interventions/alternatives and behavior committee recommendations. b. Obtain an order for an appropriate medication, in	F 329	administered and wait one hour before administering an anti-anxiety to determine effectiveness of medication. The behavior committee will meet monthly to review any residents with behaviors identified by daily report and point of care documentation to determine if appropriate interventions are in place. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator or designee to use audits that behavior meetings are held monthly and that appropriate interventions are in place for residents with behaviors and that residents on anti-psychotics will have AIMS testing done every 6 months while on anti-psychotics and that pain assessments are done with appropriate interventions in place. Audits will be done monthly x 3 months then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 329	Continued From page 21 an appropriate dose and corresponding diagnosis as well as medical symptom from the physician. . . . 5. If the physician prescribes an antipsychotic for the resident, a registered nurse must complete the Initial Antipsychotic Medication Assessment . . . and the Abnormal Involuntary Movement Scale . . ." Review of the facility policy titled, "Initial Antipsychotic Medication Assessment" occurred on 05/21/14. This policy, dated August 2005, stated, ". . . Use: Required PRIOR to initiating an antipsychotic medication. Purpose: To provide assessment of resident prior to initiating antipsychotic medication regimen. When Completed: Complete prior to initiating an antipsychotic medication. . . ." Review of the facility policy titled, "Abnormal Involuntary Movement Scale (AIMS)" occurred on 05/21/14. This policy, dated September 2007, stated, ". . . Use: Required prior to resident initially receiving an antipsychotic medication. . . . Purpose: To determine presence of and/or changes in any involuntary movements possibly attributed to antipsychotic . . . When Completed: Prior to resident initially receiving an antipsychotic medication. . . ." Review of the facility policy titled "Psychopharmacological Medications and Sedatvie/Hyptnotics" occurred on 05/21/14. This policy, revised January 2007, stated, ". . . Policy . . . Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: a. in excessive dose including duplicate therapy or b. for excessive duration or c. without adequate monitoring or d. without adequate indications for its use or . . . f.	F 329		

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GOOD SAMARITAN SOCIETY - MOTT	401 MILLIONAIRE AVE MOTT, ND 58646

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F 329	Continued From page 22 any combination of the reasons above. . . . " Review of the facility policy titled "Non-Pharmacological Pain Intervention" occurred on 05/21/14. This policy, revised February 2005, stated, "PURPOSE *To provide pain intervention in a non-pharmacological manner . . . Non-pharmacological interventions should be attempted first. . . ." - Review of Resident #7's medical record occurred on May 21, 2014. Diagnoses included dementia, depression, paranoia, and anxiety. A quarterly Minimum Data Set (MDS), dated 03/02/14, identified the resident as moderately cognitively impaired, experienced physical behavioral symptoms directed toward others one to three days, verbal behavioral symptoms directed toward others one to three days, other behavioral symptoms not directed toward others one to three days, rejected care one to three days, wandered one to three days, and took an antidepressant six of seven days. Resident #7's current care plan stated, "Focus: The resident has behavior symptoms of accusing staff of stealing personal items and has displayed physical abuse of scratching and verbal abuse of screaming at staff. Date initiated 03/03/14 . . . Interventions: Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Provide opportunity for positive interaction, attention. Stop and talk with her as passing by. Minimize potential for resident's disruptive behaviors of accusing staff of stealing by offering tasks which divert attention such as sit in her room & [and] look through her mail or have her	F 329		

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F 329	Continued From page 23 write down her concerns, as she does like to write." Review of the physician's orders identified the following medications: * Zoloft (an antidepressant) 25 milligrams (mg) by mouth at bedtime daily, ordered 01/15/2014. Changed to Zoloft 50 mg on 03/19/14. * Seroquel (an antipsychotic) 25 mg by mouth at bedtime, ordered 03/19/14. Resident #7's medical record lacked an "Initial Antipsychotic Medication Assessment" and an AIMS assessment prior to the administration of the antipsychotic medication Seroquel as per facility policy. Review of progress notes from 02/01/14 through 03/19/14 showed the following: * 02/20/14, 6:47 p.m. "U/A [urinalysis] done on resident due to confusion. Showed small leukocytes and large blood. Will push fluids as recommended by infection control nurse." * Between 02/22/14 and 02/24/14 facility staff documented behaviors exhibited by the resident and identified treatment for a urinary tract infection (UTI) began on 02/22/14. On 02/24/14, facility staff documented speaking to a psychiatric consultant who did not make changes to the residents' medications due to treatment for a UTI. * 02/26/14, 10:29 a.m. "Res. [resident] is confused today. States 'I'm going to walk home. I've been here long enough'. Res. did redirect easily. . . ." * Resident #7 completed antibiotics for her UTI on 03/01/14. * 03/12/14, 4:49 p.m. "Reported res. calling activity asst. [assistant] a [derogatory name] et [and] following her around. Redirected."	F 329		

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F 329	Continued From page 24 * 03/14/14, 3:44 p.m. "hollering at room mate [sic] and wandering in to [sic] other resident's rooms insisting she 'owns this place' and wants 'that woman out of my room!', slapping at staff when they try to redirect. redirection with lots of encouragement. one on one effective." * 03/15/2014, 5:54 a.m. "Resident very confused and 'lost', staff have taken herdown [sic] to her room but she had not stayed saying 'that is not my room', staff have re-directed resident and assured her it was her room but she continued to come out as soon as staff assisted her to her room. resident finally did stay in bed after 2245 [10:45 p.m.]." * 03/15/14, 12:40 p.m. "Resident continues to be confused in regards to location of her room. Frequently asks, 'Why is that lady in my bed?' Seen standing next to roommates bed. Staff unable to re-orient to room situation, even after pointing out her personal possessions/pictures are on her side near the window. . . ." * 03/17/14, 5:24 a.m. "Resident has been awake all night ,she has had to be re-directed back to her room a few times as tend to wander into other resident's rooms" Staff documented six episodes of behaviors exhibited by Resident #7 after completion of treatment for an UTI. Five times, they were able to alter the behavior demonstrated by Resident #7 with the interventions used. One time they demonstrated interventions attempted did not change Resident #7's behavior. The facility failed to demonstrate a consistent pattern of inability to assist Resident #7 to control her behaviors with non-pharmacological interventions. Failure to complete facility required assessments, consistently identify/document the	F 329		

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F 329	Continued From page 25 actual behavior exhibited, and show the ineffectiveness of care planned and other interventions may have resulted in the initiation of an unnecessary antipsychotic medication for Resident #7. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included a cerebral vascular accident (CVA), depression, anxiety, and pain. The resident's most recent quarterly Minimum Data Set (MDS), dated 02/26/14, indicated intact cognition, mild depression, and the presence of frequent severe pain with scheduled pain medications. Current scheduled medications included BuSpar 20 milligrams (mg) daily for anxiety, Klonopin 1 mg daily for anxiety, Seroquel 50 mg at bedtime and 25 mg three times daily for unspecified psychosis, and Tylenol 500 mg three times daily for generalized pain. Review of Resident #2's current care plan included the following focus with interventions for anxiety and pain: * Focus: "The resident has an actual psychosocial well-being problem R/T [related to] Anxiety E/B [evidenced by] frequent hollering out and disruptive behaviors." * Interventions: "* Remove resident to a calm safe environment and allow to vent/share feelings when conflict arises. * Consult with: Pastoral care and/or psych services as needed. "Allow resident time to answer questions and to verbalize feelings, perceptions, and fears as needed." * Focus: "The resident has chronic pain/discomfort to L) [left] leg and back." * Interventions: "* Provide resident with reassurance that pain is time limited. Encourage resident to try different pain relieving methods i.e.	F 329		

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F 329	Continued From page 26 [for example] positioning, relaxation therapy, and heat and cold application. * Observe/record/report to Nurse any s/s [signs/symptoms] of non-verbal pain: . . . vocalizations (grunting, moans, yelling out, silence); mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion). . . ." Review of Resident #2's March and May 2014 electronic medication administration record (EMAR) identified PRN Xanax 0.5 mg for anxiety administered five times without non-pharmacological interventions attempted and/or specific behaviors documented. Review of Resident #2's March, April, and May 2014 EMAR identified PRN Tylenol 650 mg for pain administered seven times without non-pharmacological interventions attempted. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included traumatic fracture, pain, anxiety, and depression. The resident's most recent quarterly MDS, dated 05/07/14, indicated severely impaired cognition, minimal depression, physical and verbal behaviors, no pain present with a scheduled pain medication. Current scheduled medications included Ativan 0.5 mg at bedtime for anxiety, BuSpar 10 mg three times daily for anxiety, Norco 5-325 mg two times daily for sacrum pain, Remeron 15 mg at bedtime for depression, and Zyprexa 5 mg daily for anxiety. Review of Resident #3's current care plan included the following focus with interventions for anxiety and pain: * Focus: "The resident has a psychosocial well-being problem R/T Anxiety, especially at	F 329		

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F 329	Continued From page 27 bedtime." * Interventions: "* Consult with: Pastoral care, psych services, or primary MD as needed. * Discuss resident's feelings relative to feelings of anxiety and provide support and reassurance. * Allow resident time to answer questions and to verbalize feelings perceptions, and fears as needed." * Focus: "The resident has depression and anxiety.*" * Interventions: "* Assist resident in developing/Provide resident with a program of activities that is meaningful and of interest such as watching sports on TV. . . Provide support and reassurance PRN. Monitor/record/report to health care provider PRN risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of objects that could be used as weapons." * Focus: "The resident has generalized pain/discomfort." * Interventions: "* Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to s/s or c/o [complaints of] pain or discomfort. * Notify health care provider if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. * Monitor/document for side effects of pain medication. Observe for . . . new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria . . . Report occurrences to the health care provider." Review of Resident #3's January, February, and March 2014 EMAR identified staff administered PRN Ativan 0.5 mg for anxiety twelve times without non-pharmacological interventions	F 329		

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F 329	Continued From page 28 attempted and/or specific behaviors documented. Review of Resident #3's January, February, and March 2014 EMAR identified staff administered PRN Ativan 0.5 mg for anxiety and PRN Tylenol 650 mg five times simultaneously and without non-pharmacological interventions attempted and/or specific behaviors documented to distinguish between anxiety and/or pain symptoms.	F 329		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) 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 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 425	1)The corrective action accomplished for Resident #13 related to accurate pharmacy services procedures is that the nurse verified the medication with the correct dose against the physicians order. The correct medication and dosage was delivered on 5/19/14. A new card label was received from pharmacy. 6-26-14 Kathy Greff DON 2) All residents with orders for medications have the potential to be affected by the same practice. The nurse on duty ensured that all medication cards are accurate by comparing the physician orders for each resident, the medication ordered and the dose, route and time the medication is to be given. 3) Measures put into place to ensure the practice will not recur is that licensed nursing staff was educated on 6/17/14 by DNS that all medication cards are initialed for accuracy after verification is complete. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator	06/20/14

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F 425	Continued From page 29 policies/procedure, and staff interview, the facility failed to ensure the current physician's order had been changed on the medication card label for 1 of 1 supplemental resident (Resident #13) observed during medication administration. Failure to ensure the physician's order matches the medication card label may result in the resident receiving the incorrect medication and/or dosage. Findings include: Review of the facility policy titled "Documentation of Medication" occurred on 05/21/14. This policy, revised March 2011, stated, "The following information will be documented in the medical record upon administration of medications: 1. Name and dose of drug . . . 6. Any medication error. . . ." During an observation on 05/19/14 at 7:05 a.m., a nursing staff member (#1) prepared to administer a 10 milligram (mg) daily dose of donepezil HCL as indicated on Resident #13's electronic medication administration record (EMAR). The resident's medication card identified donepezil HCL 5 mg to be given daily. The nursing staff member (#1) verified the physician wrote an order on 05/07/14 to increase the donepezil HCL from 5 mg to 10 mg daily. The nursing staff member (#1) then administered two of the 5 mg tablets. She could not verify if the correct dosage had been consistently administered since the order change, twelve days prior.	F 425	or designee to monitor by using audits that nursing staff are properly verifying the accuracy of all medications delivered. These audits will be done monthly x 3 then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		

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F 431	Continued From page 30 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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, review of controlled medication logs, review of facility procedure, and staff interview, the facility failed to ensure periodic reconciliation for controlled medications in 1 of 1	F 431	1) The corrective action accomplished related to proper storage of drugs and biologicals is that the controlled medications in the locked storage cabinet in the locked medication room have been reconciled on 6/16/14 and verified as accurate. 2) All residents with orders for medications have the potential to be affected by the same practice. Licensed nursing staff were educated by the facility's DNS on 6/17/14 on proper reconciling of controlled medications. 3) Measures put into place to ensure the practice will not recur is that licensed nursing staff was educated on 6/17/14 by DNS that two nurses will reconcile controlled medications stored in the locked storage cabinet in the medication room for accuracy. This will occur on the first and third Friday of each month. Verification will be noted in a log secured in the DNS office. During the monthly visit, the consulting pharmacist will reconcile all medications in locked storage cabinet prior to destroying discontinued controlled medications. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that nursing staff are properly verifying the accuracy of all controlled medications kept in the	06/20/14

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F 431	Continued From page 31 storage cabinet located in the medication room. Failure to periodically reconcile controlled medications has the potential to result in loss or diversion of medications. Findings include: Review of the facility procedure "Controlled Substances" occurred 05/21/14. This procedure, dated September 2012, stated, "Purpose: To provide verification and correct count of controlled substances on hand. To provide safe storage of controlled substances. NOTE: At change of shift, on-duty and oncoming nurses count according to specific state law. . . . Procedure 1. One nurse unlocks the controlled substances storage unit and counts controlled drugs, per state regulations, on hand for each resident. 2. The other nurse assists by watching and verifying the count in the Individual Resident Narcotic Record . . . or alternate Controlled Substance Record . . ." Observation in the medication room occurred on 05/21/14 at 1:05 p.m. with a licensed nurse (#1). Observation showed a wall mounted double locked storage cabinet in the medication room. The cabinet contained extra controlled medications for stocking the medication cart and controlled medications for destruction. The cabinet contained following controlled medications for destruction: * Oxycodone 5 milligram (mg) tablets, two cards, 13 tablets and six tablets. * Tramadol 50 mg, one card, eight tablets. * Lorazepam 0.5 mg, one card, 24 tablets. * Alprazolam 0.25 mg, one card, 26 tablets. The nurse (#1) identified the resident count sheets have the current counts for the medication	F 431	locked storage cabinet in the med room. The audits will include nursing staff as well as the consultant pharmacist. These audits will be done monthly x 3months then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 431	Continued From page 32 cards in the medication cart. Staff store medication cards that are full and do not fit in the medication cart in the cabinet. The nurse (#1) identified these cards and discontinued medications stored in the cabinet are not counted. The nurse (#1) obtained a count sheet for the discontinued alprazolam, which showed 27 tablets, not 26 as was contained in the cabinet.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT 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.	F 441	1) The corrective action accomplished for Residents #1, #3, & #4 related to infection control procedures is that nursing staff has received training on 6/17/14 on proper hand hygiene. 2) All residents in the facility are identified with potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that nursing staff was educated on 6/17/14 by DNS on proper hand washing procedures. Facility procedure for hand-washing was distributed and reviewed at the in-service. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that nursing staff are following proper hand hygiene. These audits will be done weekly x 1, monthly x 3 then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	06/20/14

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F 441	Continued From page 33 (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. This REQUIREMENT is not met as evidenced by: Based on observation, review of policies/procedures, and staff interview, the facility failed to ensure staff performed proper hand hygiene for 3 of 6 sampled residents (Resident #1, #3, and #4) observed during resident care and perineal cares. Failure to follow infection control practices related to hand hygiene has the potential to result in the spread of infection to other residents, family, visitors, and staff. Findings include: Review of the facility policy titled "Hand Hygiene and Handwashing" occurred on 05/21/14. This policy, dated November 2013, stated, ". . .Wash hands with plain soap and water or with anti-microbial soap and water: *If hands are visibly soiled (dirty) *if hands are visibly contaminated with blood or body fluids . . . If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning your hands: *Before having direct contact with residents *After having direct contact with a resident's skin *After having	F 441		

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F 441	Continued From page 34 contact with body fluids, wounds or broken skin *After touching equipment or furniture near the resident *After removing gloves . . ." - During an observation of care for Resident #4 on 05/20/14 at 9:50 a.m., certified nursing assistants (CNAs) (#6 and #7) provided perineal cares after an incontinent bowel movement. While one CNA (#7) assisted the resident to roll on her side in bed, the other CNA (#6) provided perineal cares. After providing care the CNA (#6) removed her gloves, gave the resident her call light, adjusted the blankets, offered the resident a drink of water, and then performed hand hygiene. - During observation on 05/20/14 at 10:45 a.m., two CNAs (#3 and #5) toileted Resident #3 in his bathroom using a stand lift for transfer. The CNA (#3) donned gloves, cleansed bowel movement from the resident's perineal area with a moistened wipe, removed her gloves, helped transfer the resident to a wheelchair, and removed the stand lift from the room to a storage area. The CNA failed to perform hand hygiene after completing perinial care and prior to completing other tasks. The CNA (#3) then entered Resident #1's room with a full body lift, helped transfer the resident from the bed to a wheelchair, removed the body lift from the room to a storage area, and entered another resident's room to answer the call light. During an interview on 05/20/14 at 1:15 p.m., a CNA (#3) indicated staff could carry hand sanitizer in their pockets or use the sanitizer dispensers located in the hallways. The CNA (#3) did not have sanitizer in her pocket.	F 441		
F 494	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO -	F 494		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355099	A. BUILDING _____ B. WING _____	05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 494 SS=B	Continued From page 35 TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter. This REQUIREMENT is not met as evidenced by: Based on information from the nurse aide registry, the facility failed to ensure 1 of 1 direct care staff (Individual A) who provided resident care maintained a current certification. Failure to ensure certification of caregivers placed residents at risk of receiving care from unqualified staff. Findings include:	F 494	1)The corrective action related to CNA certification is that the North Dakota CNA registry was checked to confirm that this CNA has a current certification. 2) All residents in the facility are identified with potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that nursing staff was educated on 6/17/14 by DNS on keeping their certificates and licenses current. The facility will have all CNA's and nurses provide a current copy of their CNA certifications and nurse licenses to the staff development coordinator. The staff development coordinator has implemented a monthly tickler file whereby reminders will be sent to nursing staff on a monthly basis when their certifications/licenses are due for renewal. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that nursing staff are current with their certifications/licenses. Audits will indicate that a system is now in place where Staff Development or designee will track and remind nursing staff on a monthly basis prior to when their renewals are due. A copy of their current status will be placed in employee files. Audits will be completed by SD or designee monthly x 3 and then quarterly x 3. Results will be reported to the QA team with corrective action implemented.	06/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 494	Continued From page 36 Information from the North Dakota nurse aide registry identified Individual A's nurse aide certification expired on 04/27/2014. This information showed Individual A worked 14 days, 04/29-30/14, 05/02-04/14, 05/06/14, 05/09/14, 05/13-14/14, 05/16-19/14, and 05/21/14, with an expired certification.	F 494		