| 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 _____ | 08/15/2019 |

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

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>The Standard Medicare/Medicaid recertification survey started on 08/13/19 and concluded on 08/15/19. | F 000 | | |
| F 567 SS=E | Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii)<br><br>§483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds.<br>(i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.<br>(ii) Deposit of Funds.<br>(A) In general: Except as set out in paragraph (f)( l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.<br>(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any | F 567 | | 9/9/19 |

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

Electronically Signed | 08/27/2019

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| F 567 | Continued From page 1<br>of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interviews, the facility failed to have a system in place for 1 of 10 sampled residents (Resident #23) interviewed who expressed concerns regarding her inability to access her funds on weekends. Failure to provide residents access to their personal funds during the evening and/or on the weekend limited the residents' rights to have access to their money.<br><br>Findings include:<br><br>During an interview on 08/13/19 at 4:23 p.m., when asked if she had access to her personal funds, Resident #23 stated, "You have to get it on Friday, because there is no one there on the weekend."<br><br>During an interview on 08/15/19 at 8:35 a.m., a managerial staff member (#3) stated, "Residents have access to their personal funds. Most of the people know they are going to go out, come Thursday-Friday. We also have residents who get pop throughout the day and need quarters. If they know ahead of time, they can get it." The managerial staff member (#3) confirmed residents have no current access to their funds during the evening and/or on the weekend. | F 567 | 1) The corrective action accomplished for all residents that have a Resident Trust Account (RTA) was that the RTA petty cash box was put in a locked cabinet for only authorized personnel to have access to resident funds during evenings and weekends and was set up on 8-21-19.<br><br>2) The facility recognizes that all residents have the potential to be affected by the same practice.<br><br>3) The measures put into place to ensure the practice will not recur is the RTA money will be in an interest bearing account that is separate from the facility's operating accounts, and that credits all interest earned on resident's funds to that account. This RTA money will be in a locked labeled cabinet in the main business office with a ledger of which residents have money and how much each resident has available. Another form is accompanied with the petty cash box to keep track of all transactions and full amount of money in RTA petty that is available. This form GSS #92 will show the time, date, name, amount the resident | |

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| F 567 | Continued From page 2 | F 567 | received and amount left in the RTA petty cash box.<br><br>The nurses have a key for the RTA petty cash box and will make sure the forms are filled out.<br><br>Administrator and Business Manager or designee will count the RTA petty cash box every Monday morning to verify the balance.<br><br>The GSS #92 will be filed in a binder and the transactions entered into the computer. A new GSS #92 and a new resident ledger of the resident's balance will accompany the RTA petty cash box and will be locked in cabinet every Monday morning.<br><br>When the Business Office is open the residents will come to the Business Office to receive any money they may need.<br><br>The residents will be informed at resident council meeting on 9-09-19. The nurses will be educated on this procedure during a licensed Nursing Staff meeting on or before 8-30-19.<br><br>4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Business Manager or designee to monitor by using audits to ensure residents have access to funds as requested. Audits will be done weekly X 4, monthly X 3, then quarterly X 1 year. Results will be reported to the QA | |

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| F 567 | Continued From page 3 | F 567 | team with corrective action implement.<br><br>5) Corrective action completion date 9-09-19. | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based record review and review of the facility policy, the facility failed to review and revise the | F 657 | F 657<br>1) The corrective action accomplished | 9/9/19 |

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| F 657 | Continued From page 4<br>comprehensive care plan to reflect the current status for 2 of 14 sampled residents (Resident #6 and #30). Failure to revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each resident.<br><br>Findings include:<br><br>Review of the facility policy titled "CARE PLAN" occurred on 08/15/19. This policy, revised on November 2016, stated, ". . . Care plans . . . will be modified to reflect the care currently required/provided for the resident. . . ."<br><br>Review of the facility policy titled "COMPREHENSIVE CARE PLAN AND CARE CONFERENCE" occurred on 08/15/19. This policy, revised on May 2019, stated, ". . . care plans must be revised as the resident's needs/status changes . . ."<br><br>- Review of Resident #6's medical record occurred on all days of survey. Current physician orders stated, ". . . Warfarin Sodium (blood thinning medication) 2.5 milligram (mg) by mouth one time a day related to Cardiac Arrhythmia, Transient Cerebral Ischemic Attack. . . ."<br>The current care plan failed to address Resident #6's use of a blood thinning medication.<br><br>- Review of Resident #30's medical record occurred on all days of survey. The current care plan stated, " . . . Resident is on Contact isolation as ordered upon return from hospitalization . . . Revision on: 04/03/2019. . . ."<br><br>The facility staff failed to discontinue the intervention for contact isolation. | F 657 | for Residents #6 and #30 whose care plans were found to not reflect their current status is that the care plans for Resident #6 and #30 have been revised and updated on 08/16/2019 to accurately reflect their current status along with appropriate goals and interventions to manage them.<br><br>2) The facility recognizes that all residents have the potential to be affected by the same practice.<br><br>3) Measures put into place to ensure the practice will not recur is that the DNS will educate Licensed Nursing Staff at a Nursing Meeting on or before 8/30/2019 regarding the care planning process for care plans requiring revision to reflect the residents current status along with appropriate goals and interventions to ensure effective communication and continuity of care for each resident.<br><br>4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA nurse or designee to monitor by using audits to ensure that care plans are updated to reflect each resident s current status. Audits will be completed weekly x4, monthly x 3, then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.<br><br>5) Corrective action completion date: 9/9/2019 | |

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| F 761 SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, and staff interview the facility failed to store medications in a secure manner in 1 of 2 medication storage rooms. Failure to store all medications securely may result in unauthorized access to medications and/or medications errors.<br><br>Findings include: | F 761 | F 761<br>1) The corrective action accomplished regarding the improper storage of drugs and biologicals is that all medications stored in the south medication storage room were removed and placed in locked cabinets on 8/29/2019 so that only authorized personnel including the director of nursing services or the person | 9/9/19 |

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| F 761 | Continued From page 6<br>Review of the facility policy titled "Acquisition, Receiving, Dispensing and Storage of Medications" occurred on 08/15/19. This policy, dated September 2016, stated, ". . . once medications are delivered, they will be secured in an appropriate storage area . . . medications will be stored in a locked medication cart, drawer or cupboard. Only the person passing medications and the director of nursing services will be permitted to have access to the keys to the medication storage area . . ."<br><br>During an observation of a medication storage area occurred on 08/14/19 at 9:53 a.m. with a licensed staff nurse (#2) showed multiple medications on shelves. Medications stored in this area included: bottles of extra strength Tylenol, naproxen sodium, Aspirin, Melatonin, Omeprazole, and others. The storage also contained wheelchairs, walkers and other medical supplies. The key to the storage door is placed in an unlocked fire extinguisher cabinet next to the storage room for staff access, which also has the potential for residents to access the key.<br><br>During an interview on 08/15/19 at 1:35 p.m., an administrative nurse (#1), agreed the medications need to be stored securely and separate from other equipment. | F 761 | passing the medications will have access to the keys to the medication storage areas.<br><br>2) The facility recognizes that all residents have the potential to be affected by the same practice.<br><br>3) Measures put into place to ensure the practice will not recur is that the DNS will educate Licensed Nursing Staff at a Nursing Meeting on or before 8/30/2019 regarding the facility□s process for safe storage of all medications.<br><br>4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA nurse or designee to monitor by using audits to ensure all medications are securely stored in locked compartments with access permitted to only authorized personnel. Audits will be done weekly x4, monthly x3, then quarterly x1 year. Results will be reported to the QA team with corrective action implemented.<br><br>5) Corrective action completion date: 9/9/2019 | |