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

PRINTED: 09/08/2011
FORM APPROVED
OMB NO. 0938-0391

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 _____	08/31/2011

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
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on August 29, 2011 and completed on August 31, 2011, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 4 additional residents to verify specific concerns during the survey.	F 000	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.	
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	1) Since the window of time to ensure proper notification that Medicare coverage ended is past for Residents #11, 12 and 13, the corrective action is that the Medicare Coordinator and/or designee was informed of the oversight and resident records were checked to ensure that all other resident on Medicare were being properly notified. Currently, no other residents are affected.	09/23/11

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

Eunice Kalla | Administrator | 9/19/2011

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

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 _____	08/31/2011

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
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 the advance directives requirements.	F 156	2) The facility recognizes that all residents whose Medicare coverage ends have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that the Medicare Coordinator and/or designee has been supplied with the proper notification forms and educated on the proper procedures for providing the Notice of Medicare Provider Non-Coverage (CMS Form 10123). All education was completed on 9/6/2011. 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 proper notification forms are being properly used and sent to any residents whose Medicare coverage ended. These audits will be done monthly x 3 months and quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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 _____	08/31/2011

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
F 156	Continued From page 2 The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. 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 review of the facility's Medicare billing records and staff interview, the facility failed to provide a Notice of Medicare Provider Non-Coverage (CMS Form 10123) to 3 of 3 supplemental residents (Resident #11, #12, and #13) whose Medicare coverage ended. Failure to provide required notices to residents whose Medicare coverage is ending is an infringement of the residents' rights.	F 156		

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 _____	08/31/2011

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
F 156	Continued From page 3 Findings include: Review of the facility's Medicare billing records occurred on 08/31/11. The records showed Resident #11, #12, and #13's coverage ended on the following days: *Resident #11: 07/14/11 *Resident #12: 07/11/11 *Resident #13: 06/11/11 The records identified the residents' coverage ended as a result of no longer requiring daily skilled nursing services, but they would remain at the facility. This situation required facility staff to send denial notices as well as a CMS Form 10123 to these residents; however, review of Medicare billing records showed staff failed to send the CMS Form 10123. During an interview on 08/31/11 at 1:15 p.m., a supervisory nursing staff member (#3) stated she had not sent the CMS Form 10123 to any residents whose coverage ended.	F 156		
F 309 SS=D	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: Based on observation, record review, staff	F 309	1) The corrective action accomplished for Resident #3 and #7 found to have been affected by the practice that residents have the right to receive thickened liquids and receive such in a safe manner is that nursing staff have a visual reminder on both their assignment sheets and hand held devices noting which residents are on thickened liquids. In addition, any resident identified as needing thickened liquids will have the drinking container in their room labeled as "thickened liquids only."	09/23/11

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 _____	08/31/2011

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
F 309	Continued From page 4 interview, review of facility policy, and professional literature review, facility staff failed to provide care and services to maintain the residents' highest practicable physical well-being for 2 of 2 sampled residents (#3 and #7) who have physician orders for and are care planned to receive thickened liquids. Failure to provide thickened liquids and/or provide thickened liquids in a safe manner has the potential to cause choking and places residents at risk for aspiration. Findings include: Review of the facility policy titled "Thickened Liquids" occurred on 08/31/11. This policy, dated January 2009, stated, "Purpose: To ensure all clients will be served liquids in a form to minimize the risk of choking or aspiration and in compliance with the physician order for thickened liquids. . . 11. Nursing staff will be responsible for providing and thickening when necessary [sic] thickened beverages given to residents between meals . . ." Nancy B. Swigert, The Source for Dysphagia, third edition, LinguiSystems, Inc., East Moline, IL, 2007, page 125, stated "During the oral intake of medicines, foods and/or liquids, it is optimal for a patient to be seated at a 90 [degree] angle, whether in a bed or in a chair." - Resident #3's medical record, reviewed August 29-31, 2011, identified a diagnosis of dementia. The resident's quarterly Minimum Data Set (MDS), dated 06/22/11, identified severely impaired cognitive skills and extensive assist of one person for eating.	F 309	2) Other residents having the potential to be affected by the same practice have been identified by querying MDS 3.0 section K0100C; Residents choking on liquids and it was found that no other residents are receiving thickened liquids. 3) Measures put into place to ensure the practice will not recur is that nursing staff will be educated on 9/21/2011 on the use of thickened liquids, as well as the proper positioning for residents with swallowing problems 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 that proper positioning is occurring and appropriate liquids are being given. Audits will be done monthly x 3 then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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 _____	08/31/2011

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
F 309	Continued From page 5 A form titled "Dysphagia Evaluation and Plan of Treatment," dated 04/14/11, identified facility staff requested an evaluation for Resident #3 for swallowing as he coughed while consuming liquids. Based on the therapist's evaluation, recommending nectar thick liquids with mechanical soft diet, the physician ordered "nectar liquids/mechanical soft diet" on 04/14/11. The care plan for Resident #3, dated 06/27/11, identified the following: "Problems/Needs/Concerns: I don't drink fluids like I should . . . I have been doing a lot of coughing when I drink liquids. . . . Plans and Approaches: Offer me water with cares [and] PRN [as needed] . . . Swallow evaluation done. Give me nectar thick liquids [and] mechanical soft diet to decrease aspiration [and] choking." Observation of care for Resident #3 occurred on 08/30/11 at 6:37 a.m. Two certified nurse aides (CNAs) (#1 and #2) provided morning cares for the resident. After cares, the CNA (#2) obtained water from the bathroom faucet and gave Resident #3 a drink of unthickened water. The resident began to cough as he drank the water. The CNA (#2) paused while the resident coughed, then gave Resident #3 more unthickened water, and he coughed again. After the second time Resident #3 coughed, the CNA (#2) did not offer more unthickened water. - Resident #7's medical record, reviewed 08/31/11, identified diagnosis including dementia and shortness of breath. The resident's significant change MDS, dated 06/24/11, identified	F 309		

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 _____	08/31/2011

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
F 309	Continued From page 6 moderately impaired cognitive skills and limited assist of one person for eating. A physician order, dated 06/20/11, stated, ". . . Nectar thick liquids." The care plan for Resident #7, dated 06/30/11, identified the following: "Problems/Needs/Concerns: 06/30/11: I don't drink fluids like I should . . . Plans and Approaches: . . . Offer me water with cares . . . Problems/Needs/Concerns: I have nectar thick liquids . . . Plans and Approaches: . . . Serve nectar thick fluids. . . ." Observation of care for Resident #7 occurred on 08/31/11 at 8:57 a.m. Two CNAs (#1 and #4) assisted the resident to lie down after breakfast, positioned the resident to her left side and elevated the head of the bed less than 30 degrees. The CNA (#4) obtained a glass of thickened water from the bedside and gave Resident #7 a drink of water without first raising the head of the bed to a 90-degree angle. In an interview on the morning of 08/31/11, an administrative staff member (#3) identified staff are to provide Resident #3 with thickened fluids when providing fluids in his room. This same staff member (#3) identified staff should offer Resident #7 a drink of thickened water prior to assisting her to bed.	F 309		
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	F 323	1) The corrective action accomplished for Residents #6, #8 and #9 found to have been affected by the practice that safe transfer with gait belts occur is	09/23/11

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 _____	08/31/2011

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
F 323	Continued From page 7 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of policy and procedure, and staff interview, the facility failed to ensure each resident received adequate supervision and assistance devices for 3 of 3 sampled residents (Resident #6, #8, and #9) who required assistance with transfers. Failure to use a gait belt appropriately or as necessary has the potential to cause falls, injuries, or pain to residents. Findings include: Review of the facility procedure titled "Gait (Transfer) Belt" occurred on 08/31/11. The procedure, dated January 2009, stated "Purpose: To safely transfer or ambulate resident. To aid resident in maintaining balance. To avoid injury to both resident and staff member. Note: Gait belts used unless medically contraindicated. Procedure: . . . 2. Place belt around resident's waist over clothing, if over bare skin place a towel under the gait belt. . . . 4. Make sure belt is securely buckled so it does not slide. Belt should not be twisted and should be just snug enough so you can get your fingers under it. . . ." - Review of Resident #6's medical record occurred on August 29-31, 2011. Diagnoses included vertigo (dizziness), osteoporosis, degenerative joint disease, and Alzheimer's	F 323	that CNA's were educated in report on 8/31/2011 and 9/2/2011 on proper procedure of tightening the gait belt around the resident so the device will not slide up thus risking injury to the resident. 2) Other residents having the potential to be affected by the same practice have been identified by the DNS/designee querying MDS 3.0 section G0300B; Resident Balance, Walking w/ assistive devices. Residents identified have been assessed by Restorative Services Coordinator or designee for gait belt need and use and the care plans have been updated. 3) Measures put into place to ensure the practice will not recur is that nursing staff will be educated by the Physical Therapist on the proper use of gait belts on 9/21/2011. 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 proper use of gait belts with transfers. Audits will be done monthly x 3 then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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 _____	08/31/2011

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
F 323	Continued From page 8 disease. The nurse's notes showed Resident #6 experienced five falls since March 2011. The careplan, dated 08/08/11, stated ". . . needs assist of 1-2 with transfers, walking in her room . . . potential for falls due to unsteady gait . . ." On 08/30/11 at 10:06 a.m., two certified nurse aides (CNAs) (#5 and #6) assisted Resident #6 to stand from the wheelchair by holding the gaitbelt around her waist. The gaitbelt slid up under Resident #6's armpits and onto her chest. Resident #6 indicated verbal discomfort at the position of the gaitbelt and attempted to lower it off her chest. One CNA (#5) pulled the gaitbelt lower, but failed to tighten the gaitbelt. Resident #6 ambulated holding onto a platform walker, with the CNAs on each side of the resident holding onto the loose-fitting gaitbelt. On 08/30/11 at 10:13 a.m., two CNAs (#5 and #7) brought Resident #6 into the tub room and removed her sweater, sweatshirt, and undershirt. One CNA (#7) placed a gaitbelt around the resident's bare upper waist. The CNA failed to place a towel under the gaitbelt or position it snug against her body. As the CNAs assisted Resident #6 to stand and transfer into the tub chair the gaitbelt pulled upward on the resident's back and up under her breasts. - Review of Resident #8's medical record occurred on 08/31/11. Diagnoses included dementia and osteoarthritis. A nursing assessment, dated 07/10/11, stated Resident #8 required assistance from two staff members and the use of a walker and a gait belt for transfers. On 08/30/11 at 8:05 a.m., a CNA (#6) placed a	F 323		

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 _____	08/31/2011

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
F 323	Continued From page 9 gaitbelt around Resident #8's waist and failed to pull it snug. The CNA held onto the gaitbelt and assisted Resident #8 to stand from her wheelchair. The gaitbelt slid up under the resident's right armpit upon standing and transferring to a dining room chair. - Review of Resident #9's medical record occurred on 08/31/11. Diagnoses included muscle spasms and Parkinson's disease. The careplan, dated 07/07/11, stated ". . . I am at risk for falls, due to weakness & [and] I have fallen frequently. . . . I use a FWW [front-wheel walker] for ambulation. Walk with me & use a gait belt prn [as needed]. The Care Area Assessment (CAA), dated 08/01/11, stated under Falls: ". . . poor eyesight and poor balance - implement steps to keep from falling." A "Nursing Documentation" form, dated 07/26/11, stated under Additional Comments: ". . . Transfers and ambulates [with] gaitbelt and assist of [one]." Observation on the morning of 08/30/11 showed a nursing staff member (#8) assisted Resident #9 to stand and ambulate down the hallway using a front-wheel walker. The staff member held on to the waistband of Resident #9's pants and failed to apply a gait belt. During an interview on 08/31/11 at 11:20 a.m., an administrative nurse (#3) agreed a gaitbelt should be pulled snug. At 2:40 p.m., this nurse further stated facility staff should use a gaitbelt when ambulating Resident #9.	F 323		
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	1) The corrective action accomplished to ensure that all medications are properly disposed is	09/23/11

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 _____	08/31/2011

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
F 431	Continued From page 10 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, policy and procedure review, record review, and staff interview, the facility failed to ensure outdated	F 431	that the outdated insulin bottles were disposed of immediately on 8/30/2011. In addition, the Pharmacy Consultant or designee has reviewed the expiration dates on all medications in the med room. 2) The facility recognizes that all residents receiving medications have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that licensed nursing staff will be in educated by the DNS or designee on 9/21/2011 on the facility policy and procedure for outdated medications. The DNS and nurse designee will check for outdated drugs after the monthly pharmacy review committee meeting. The Pharmacy Consultant was contacted on 9/16/2011 regarding a system for the disposition of medications. An audit will be done quarterly by the Pharmacy Consultant to review that expired medications have been properly disposed. 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 to check for outdated medications in the med room.	

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 _____	08/31/2011

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
F 431	Continued From page 11 medications/biologicals were discarded after the recommended usage period in 1 of 1 Medication Room. Failure to dispose of opened insulin vials allows usage beyond the recommended expiration date. This practice may affect the potency and sterility of the insulin. Findings include: On 08/30/11 at 9:00 a.m. during the Medication Room tour with a staff nurse (#8), observation showed one vial of Lantus insulin for Resident #14 with an open date of 07/19/11 and one vial of Humalog insulin for Resident #14 with an open date of 07/25/11. The nurse stated both insulins should have been discarded after 28 days and placed them in the medication discard bin. Review of the facility procedure titled "Insulin Administration" occurred on 08/31/11. The procedure, dated January 2009, stated ". . . Procedure: Note: Multi-dose vials should have 'open date' written on vial. Insulin should not be used if over 28 days old after the bottle was opened. . . ." Review of Resident #14's Medication Administration Record (MAR) occurred on 08/31/11. The MAR, dated 08/01/11, included the following orders: * "Lantus (Insulin Glargine injection) 18 units (SQ) [subcutaneous] every A.M. [morning]" * "Humalog (Lispro) 17 units (SQ) at breakfast . . ." * "Humalog (Lispro) 4 units (SQ) at supper" * "Humalog (Lispro) (SQ) BID (twice daily) sliding scale . . ."	F 431	Audits will be done monthly x 3 then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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 _____	08/31/2011

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
F 431	Continued From page 12 The Lantus insulin expired on 08/16/11 and the Humalog insulin expired on 08/22/11. The MAR showed staff administered the Lantus insulin for 14 days after the expiration date and the Humalog insulin for 8 days after the expiration date.	F 431		