| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355095 | A. BUILDING _____ B. WING _____ | 07/25/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOOD SAMARITAN SOCIETY - OAKES | 213 N 9TH ST OAKES, ND 58474 |

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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey, started on 07/23/12 and completed on 07/25/12, the sample included 5 residents for complete review, 12 residents for focused review, and 3 closed records for review. | F 000 | F: 225<br><br>1. The facility has replaced the computer for resident # 16 and all appropriate agencies are aware of this misappropriation of property. | |
| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>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.<br><br>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).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated | F 225 | 2. All Residents have the potential to be affected by this same deficient practice.<br><br>3. The incident committee, which includes the administrator, will investigate all reports of lost items and/or misappropriation of property. Per policy, and when deemed necessary, the Social Worker or designated staff will report the results of the investigation to the state survey and certification agency within (5) working days of the incident. Outside officials and agencies will also be contacted as appropriate or required by state law. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| David Carda | Administrator | 8-22-12 |

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

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| F 225 | Continued From page 1<br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of resident council meeting minutes, review of facility policy, and staff interview, the facility failed to immediately report 1 of 1 allegation of misappropriation of resident property (Resident #16), and failed to report the findings of the investigation within five working days to the state survey and certification agency.<br><br>Findings include:<br><br>Review of the facility policy "Abuse Definitions" occurred on July 24-25, 2012. The policy, revised 01/2011, stated, "Purpose - To define terminology related to abuse. Definitions . . . Misappropriation of Resident Property: Deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent."<br><br>Review of the facility policy "Abuse and Neglect" occurred on July 24-25, 2012. The policy, revised on 01/2011, stated, "Purpose - To ensure that the center has in place an effective system that . . . prevents . . . misappropriation of their property. . . 5. Notification Procedures: a. Notify the center administrator immediately of any incidents of . . . misappropriation of resident property . . . c. Notify | F 225 | 4. An audit will be developed to show compliance of reporting misappropriation of resident's property to all necessary agencies. Audits will be done by the QA Coordinator or designee monthly for 3 months, and then as deemed necessary by the QA committee.<br><br>5. The Corrective action will be complete by August 29, 2012. | |

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| F 225 | Continued From page 2<br>the designated agencies in accordance with state law, including the state survey and certification agency. . . . 9. the social worker or designated staff will report the results of all investigations to the state survey and certification agency . . . within five (5) working days of the incident . . ."<br><br>Review of the facility policy "Missing Items" occurred on July 24-25, 2012. The policy, revised 06/2012, stated, "Purpose - To promptly report possible misappropriation of a resident's property. To notify all appropriate persons. . . Procedure . . . 8. Outside officials or agencies also will be contacted as appropriate or required by state law. . . ."<br><br>Review of the Resident Council Meeting Minutes on July 23-24, 2012, identified on April 26, 2012, a missing laptop computer belonging to a resident from the east side and on May 24, 2012, "The laptop computer from the east side was not found."<br><br>Review of the facility investigations of allegations occurred on the morning of 07/24/12. The investigations for review, provided by the administrative nursing staff member (#3) and the social services staff member (#9), failed to include the investigation of Resident #16's missing lap top computer.<br><br>During interview on 07/24/12 at 10:40 a.m., an administrative staff member (#5) confirmed he failed to report the missing laptop computer to the state. This staff member stated the facility conducted an investigation, notified the police, and replaced the computer when it was not found. | F 225 | | |

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| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to provide care and services in accordance with physician's orders for 1 of 2 sampled residents (Resident #7) with TED (Thrombo-Embolic Deterrent) hose (a medically prescribed tight-fitting stocking used to help prevent the pooling of blood and formation of blood clots). Failure to ensure Resident #7 wore the TED hose as ordered may result in negative physical effects such as blood clot formation.<br><br>Findings include:<br><br>Review of Resident #7's medical record occurred on all days of survey. Diagnoses included a history of stroke with left-sided deficits, stasis edema, and hypertension. The current Minimum Data Set (MDS), dated 04/24/12, identified moderately impaired cognition, extensive assistance from two or more people for transfers, and extensive assistance from one person for dressing.<br><br>Current physician's orders stated, ". . . Stasis edema . . . TED hose on in AM off in PM . . ." | F 309 | F: 309<br><br>1. The facility will ensure that resident # 7 will have TED hose on as per physician's order and the care plan.<br><br>2. All Residents who have orders for TED hose have the potential to be affected by this same deficient practice.<br><br>3. Staff was educated on August 9, 2012 of the importance of TED hose and why placement is so important. | |

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| F 309 | Continued From page 4<br><br>Resident #7's current care plan stated, ". . . Potential for alteration in skin integrity r/t [related to]: edema . . . Plans and Approaches . . . TED hose on during day/off at HS [bedtime] - assist x 1 . . ."<br><br>Observations showed Resident #7 without TED hose on her legs throughout all days of survey. Staff failed to apply the TED hose in the morning as per provider order.<br><br>During an interview on 07/25/12 at 10:37 a.m., a supervisory nursing staff member (#1) stated, "She [Resident #7] is supposed to be wearing the TED hose." | F 309 | 4. An audit will be developed to show compliance of the placement of TED hose on residents who have orders for them. Audits will be done by the QA Coordinator or designee weekly for 1 month, monthly for 3 months, and then as deemed necessary by the QA committee.<br><br>5. The Corrective action will be complete by August 29, 2012. | |
| F 332 SS=D | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br><br>The facility must ensure that it is free of medication error rates of five percent or greater.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of policy and procedure, record review, and staff interview, the facility failed to ensure a medication error rate of less than five percent during observation of medication administration on 3 of 3 days (July 23-25,2012) of survey. Failure to wait one minute between puffs for inhaled medication (Resident #16 and #17) and administer the medication ordered by the physician (Resident #4) resulted in inaccurate doses and incorrect medications administered. Four errors occurred during administration of 40 medications, resulting in a 10 | F 332 | | |

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| F 332 | Continued From page 5<br>percent error rate.<br><br>Findings include:<br><br>Review of the facility policy, "Inhalant Medication" occurred on 07/25/12. The policy, revised January 2009, stated, "Purpose - To administer an inhalant medication in a safe manner - To aid a resident who cannot self-administer inhalant. . . . Procedure 11. If a second puff of any ordered inhalant is ordered, wait one minute between puffs. . . ."<br><br>Review of the facility policy "Administration of Medication" occurred on 07/25/12. The policy, revised October 2009, stated, "Purpose . . . To administer medications correctly using the center medication system. . . . Procedure . . . administer medications to the resident according to the 'Five Rights:' Right drug, Right dose . . . "<br><br>- On 07/23/12 at 3:40 p.m., observation showed a licensed nurse (#8) administered two puffs of an Albuterol inhaler to Resident #16 without waiting the required one minute between puffs of the medication.<br>- On 07/25/12 at 12:40 p.m., observation showed a licensed nurse (#6) administered two puffs of a Combivent inhaler to Resident #17 without waiting the required one minute between puffs of the medication.<br><br>- Review of Resident #4's medical record occurred July 23-24, 2012 and identified physician orders for the following medication:<br>* Glucosamine 500 milligrams (mg) / Chondroitin 400 mg, one tablet every day.<br>* B-Complex 100 mg, one tablet every day | F 332 | F: 332<br><br>1. Residents #16 and #17 continue to receive inhalers and per facility policy are administered with one minute between puffs. Resident # 4 has been given the correct dose of meds as of 7/25/12.<br><br>2. All Residents who receive stock medications and/or inhalers have the potential to be affected by this same deficient practice.<br><br>3. New stock medications with specifically marked dosages on the bottles are in the carts. The nurses/ CMA's were educated on August 2, 2012 about the proper way to give inhalers and the 5 rights of medication administration. | |

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| F 332 | Continued From page 6<br><br>On 07/24/12 at 7:40 a.m., observation showed a certified medication aide (CMA) (#7) administered the following medications to Resident #4:<br>* The CMA gave one tablet which contained Glucosamine 250 mg and Chondroitin 200 mg. or half of the dosage ordered by the physician.<br><br>During interview on 07/25/12 at 8:25 a.m., an administrative nursing staff member (#10) stated the CMA should have given two tablets of the medication Glucosamine/Chondroitin.<br><br>* The CMA (#7) also prepared to give Resident #4 a Vitamin B-Complex with Vitamin B-12 tablet. The label on the bottle did not identify the dose of 100 mg of B- Complex.<br><br>During interview on the morning of 07/25/12, the nursing staff member (#6) stated she obtained the correct medication B-Complex 100 mg from the pharmacy.<br><br>During interview on 07/25/12 at 1:25 p.m., an administrative nursing staff member (#3) stated the expectation would be to wait one minute between puffs of inhaler medication per facility policy and to check the 5 rights prior to giving medication including the right medication and the right dosage. | F 332 | 4. An audit will be developed to show compliance of the proper use of proper stock meds, of inhalers and the five rights of medication administration. Audits will be done by the QA Coordinator or designee weekly for the first month then monthly for 3 months, and then as deemed necessary by the QA committee.<br><br>5. The Corrective action will be complete by August 29 2012. | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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. | F 441 | | |

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| F 441 | Continued From page 7<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 2 of 4 sampled residents (Resident #11 and #12) | F 441 | F: 441<br><br>1. Residents' #11 and #12 were not directly affected by this deficient practice.<br><br>2. All Residents who have blood glucose monitoring done have the potential to be affected by this same deficient practice.<br><br>3. Nurses and CMA's were educated on August 2, 2012 about the importance of cleaning the Glucometer and the procedure in doing so.<br><br>4. An audit will be developed to show compliance of the nurses and CMA's in this procedure of cleaning the glucose monitor. Audits will be done by the QA Coordinator or designee weekly for one month, monthly for 3 months, and then as deemed necessary by the QI committee.<br><br>5. The Corrective action will be complete by August 29, 2012 | |

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| F 441 | Continued From page 8 | F 441 | | |

observed during blood glucose monitoring. Failure to properly sanitize blood glucose meters (devices used to measure blood sugar levels) after each use may result in the transmission of blood-borne pathogens between residents.

Findings include:

- Review of a facility policy titled "Cleaning and Disinfecting Blood Glucose Meters" occurred on 07/25/12. This policy, dated November 2011, stated, ". . . This procedure is for cleaning and disinfecting a glucose meter when it is being used between multiple residents. . . . Disinfecting . . . Note: If a bleach solution is not used, it is also acceptable to use Steris Coverage Spray HB or Sani-Cloth Disposable Wipe [germicidal wipe used to kill organisms and blood borne pathogens]. . . . After the disinfecting is complete . . . the meter should be left for a few minutes to ensure it is dry . . ."

Observation of medication pass occurred on 07/23/12 at 5:00 p.m. with a nursing staff member (#2). The nurse used a blood glucose meter to test Resident #12's blood glucose. After removing the test strip, the nurse used an alcohol wipe to clean the front of the meter, placed the meter into a case, and zipped the case. The nurse then resumed her medication pass.

During an interview on 07/25/12 at 1:17 p.m., a supervisory nursing staff member (#3) stated she expected staff to clean the glucose meter with a Sani-wipe, not an alcohol wipe.

- Observation on 07/23/12 at 11:05 a.m., showed a nurse (#4) exit a resident's room carrying a

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| F 441 | Continued From page 9<br>blood glucose meter with a test strip in the machine dotted with blood. The nurse disposed of the used test strip, set the blood glucose monitor inside a black case on top of a medication cart, removed her gloves, and washed her hands. The nurse (#4) returned to the medication cart, zipped the glucose monitor into a black case, and set the case in the bottom drawer of the medication cart. When the surveyor asked the nurse if this machine would be used on multiple residents the nurse replied "Yes." The surveyor asked how staff clean the glucose meters, and the nurse replied "with sani-wipes."<br><br>At 11:15 a.m., the nurse (#4) wheeled the medication cart to the nurses station, obtained Super-Sani Germicidal wipes from a cupboard, placed the wipes in the bottom drawer of the medication cart, and locked the medication cart. The surveyor asked the nurse (#4) if she had cleaned the blood glucose meter, and nurse indicated she had not cleaned the blood glucose monitor prior to putting it away. The nurse then opened the bottom drawer of the medication cart, obtained a germicidal wipe, and sanitized the meter.<br><br>During an interview on 07/25/12 at 11:30 a.m., a supervisory nurse (#1) confirmed nurses should sanitize the blood glucose meters after use and prior to storing. | F 441 | | |