| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 355095 | A. BUILDING _____ B. WING _____ | 07/14/2022 |

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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>The Standard Medicare/Medicaid recertification survey was started on 07/11/22 and concluded on 07/14/22. | F 000 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17.1), and staff interview, the facility failed to complete a Minimum Data Set (MDS) that accurately reflected the resident's status for 2 of 2 sampled residents (Resident #25 and #31) reviewed for pressure ulcers. Failure to accurately code the MDS may negatively affect the development of a comprehensive care plan and the care provided to the residents.<br><br>Findings include:<br><br>The Long-Term Care Facility RAI Manual, revised October 2019, pages M-3 through M-15, stated, ". . . pressure ulcer/injury risk factors . . . include the following: . . . co-morbid conditions, such as . . . diabetes mellitus . . . cognitive impairment . . . healed pressure ulcers, especially Stage 3 or 4 which are more likely to have recurrent breakdown. . . . M0150: Risk of Pressure Ulcers/Injuries . . . Coding Instructions, Code 0, no: if the resident is not at risk for developing pressure ulcers/injuries. . . . Code 1, yes: if the resident is at risk for developing pressure | F 641 | Preparation and execution of this response and plan of correction does not constitute an admission 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 allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the centers allegation of compliance in accordance with section 7305 of the state operations manual.<br><br>For Resident #25, new ARD (8/16/2022) has been determined and new MDS is in progress. Facility will code this resident as " at risk for pressure" on current, in progress MDS.<br><br>Resident #31 MDS was submitted to state and CMS for modification and accepted on 7/24/2022. Section M was updated | 8/19/22 |

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

Electronically Signed | 08/12/2022

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| F 641 | Continued From page 1<br>ulcers/injuries based on a review of information gathered . . . M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. . . . Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage. . . . M0300B. Stage 2: Partial thickness loss of dermis [underneath the outer layer of skin] presenting as a shallow open ulcer . . . Coding Instructions . . . M0300B1, Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2. Enter 0 if no Stage 2 pressure ulcers are present . . . M0300C: Stage 3 Pressure Ulcers: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. . . . Coding Instructions . . . M0300C1, Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 3. Enter 0 if no Stage 3 pressure ulcers are present . . ."<br><br>- Review of Resident #25's medical record occurred on all days of survey. The record identified diagnoses of Type 2 Diabetes Mellitus and mild cognitive impairment. The current care plan stated, ". . . potential for skin breakdown R/T [related to] aging process and history of pressure ulcer to coccyx [tailbone] E/B [evidenced by] fragile skin . . ."<br><br>The physician's orders included the following:<br>* 01/06/22, "Skin cote [aids in keeping skin free of irritation] to coccyx to help prevent further skin breakdown twice weekly and prn [as needed] in the morning every Tue [Tuesday], Fri [Friday] . . . | F 641 | correctly.<br><br>All residents with skin breakdown will be identified and coding of MDS section M will be checked for accuracy according to RAI manual and corrected as indicated. This will be completed by DNS by August 19,2022.<br><br>Education provided to MDS, by DNS on staging of pressure areas. Section M of the RAI manual was used for reference and was completed on 07/18/2022.<br><br>DNS or appointed RN will audit section M "Skin Conditions" for all MDS completed according to the MDS schedule weekly x4, bi-weekly x2, monthly x3, then as determined by QAPI committee when compliance is sustained.<br><br>Date of compliance will be sustained by 08/19/2022. | |

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| F 641 | Continued From page 2<br>"<br>* 05/12/22, "Get Ointment topically to help heal and prevent breakdown of coccyx with cares. . . . BID [twice a day] PRN . . ."<br><br>Review of Resident #25's quarterly MDS, dated 05/16/22, showed section M0150 coded "0, no" indicating not at risk for pressure ulcers.<br><br>The facility failed to code "1, Yes" on section M0150 on the MDS.<br><br>- Review of Resident #31's medical record occurred on all days of survey and identified a Stage 3 pressure ulcer on the left third toe. A physician's order, dated 05/18/22, stated, "Mepilex [foam dressing] top [sic] to affected area change Tues and Fri and PRN. . . ."<br><br>Review of Resident #31's wound assessments for the left inner third toe showed the following:<br>* 05/18/22, a Stage 3 new open area, granulation (new connective tissue) and slough (a layer/mass of dead tissue separated from surrounding healthy tissue) in the center of the wound.<br>* 05/25/22, a Stage 2 pressure ulcer with epithelialized (covering wound surfaces) tissue and minimal granulation.<br>* 06/14/22, a Stage 2 pressure ulcer with new pink epithelialized tissue forming.<br><br>Review of Resident #31's quarterly MDS, dated 06/07/22, showed Section M0300B coded for a Stage 2 pressure ulcer.<br><br>The facility failed to code Resident #31's pressure ulcer as a Stage 3 on the MDS. | F 641 | | |

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| F 641 | Continued From page 3<br>During an interview on 07/13/22 at 5:34 p.m., an administrative staff member (#3) confirmed staff failed to accurately code section M of the MDS for Resident #25 and Resident #31. | F 641 | | |
| 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 on observation, record review, review of facility policy, and resident and staff interview, the | F 657 | Pancytopenia has been added to resident #17 care plan on 07/18/2022. | 8/19/22 |

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| F 657 | Continued From page 4<br>facility failed to ensure staff reviewed and revised comprehensive care plans to reflect the residents' status for 2 of 17 sampled residents (Resident #17 and #44). Failure to review and revise the care plans limited staffs' ability to communicate needs and ensure continuity of care.<br><br>Findings include:<br><br>Review of the facility policy titled "Comprehensive Care Plan and Care Conferences" occurred on 07/14/22. This policy, dated 07/01/22, stated, ". . . the care plan is driven by identified resident issues/conditions and their unique characteristics, strengths and needs. When implemented in accordance with standards of good clinical practice, the care plan becomes a powerful, practical tool representing the best approach to providing quality care and quality life. . . . Care plans are to be reviewed with each MDS [Minimum Data Set] completed. . . . In addition to updates during a care plan review, care plans must be revised as the resident's needs/status changes. . . ."<br><br>- Review of Resident #17's medical record occurred on all days of survey. Diagnoses included pancytopenia (deficiency of all three cellular components of the blood-red cells, white cells, and platelets), benign prostatic hyperplasia (BPH) (enlarged prostate gland), rhabdomyolysis (breakdown of muscle due to muscle injury), and urine retention. The current care plan, stated, "The resident has urine retention/poor urine output . . . nurse to assess need for straight cath [catheter-tube to drain urine] daily as needed . . ." | F 657 | Resident #17 care plan has been updated to include diagnosis of BPH, rehabdomyolysis and urine retention on 08/04/2022.<br><br>Resident #44 diagnosis added: chronic lymphocytic leukemia has been added to the care plan and includes problem, goal and interventions on 07/18/2022.<br><br>This deficient practice has the potential to affect all residents.<br><br>A comprehensive review of all resident care plans will be completed by 08/19/2022. The review will include ensuring diagnosis are entered into the care plan with problem, goal and interventions. The review will also include review of physician orders with care plans to ensure orders are added or discontinued.<br><br>An audit will continue of care plans according toe the MDS schedule, and completed by DNS: weekly x4, biweekly x2, monthly x3 and then as determined by the QAPI committee when compliance is sustained. | |

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| F 657 | Continued From page 5<br>Progress notes showed the following:<br>* 05/16/22 at 9:08 a.m., "Upon skin check noted on residents left shoulder 6 cm bruise. . . he doesn't recall how he could have received this bruise. . . ."<br>* 05/20/22 at 5:10 p.m., ". . . [Resident's wife] is requesting resident to be seen in the ER (emergency room) to evaluate bruise to left shoulder. . . ."<br>* 05/20/22 at 8:26 p.m., ". . . Resident returned from . . . ER . . . DX [diagnosis] Contusion [bruise] to left shoulder . . ."<br>* 05/24/22 at 9:45 a.m., ". . . received orders to d/c [discontinue] straight cath. order as indwelling foley cath . . . ."<br><br>Resident #17's care plan failed to include goals and interventions related to pancytopenia and the facility failed to revise the care plan when the catheter changed from straight catheter to Foley catheter.<br><br>- Review of Resident #44's medical record occurred on all days of survey and identified a diagnosis of chronic lymphocytic leukemia (type of cancer of the blood and bone marrow). The quarterly MDS, dated 06/02/22, included a diagnosis of cancer.<br><br>During an interview on 07/11/22 at 1:48 p.m., Resident #44 stated "I have leukemia."<br><br>Resident #44's care plan lacked a problem, goal, and interventions for the chronic lymphocytic leukemia.<br><br>During an interview on 07/13/22 at 5:34 p.m., an administrative staff member (#3) expected staff to | F 657 | | |

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| F 657 | Continued From page 6<br>revise resident care plans when diagnoses and physician's orders are added and/or discontinued. | F 657 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>1.Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure staff followed professional standards of practice for 3 of 3 supplemental residents (#16, #43, and #348) observed during medication administration. Failure to ensure residents consumed their medications, and staff administered rapid acting insulin within 5-10 minutes of a meal may result in an adverse consequence for the residents.<br><br>Findings include:<br><br>-"The Nursing 2017 Drug Handbook," 37th edition, Wolters Kluwer, Philadelphia, page 790, stated regarding Rapid-Acting insulin,". . . give subcutaneous [by injection] immediately (5 to 10 minutes) before a meal. . . ."<br><br>Observation on 07/11/22 at 4:45 p.m. showed a nurse (#8) administered 14 units of NovoLog rapid acting insulin to Resident #16. Observation showed the resident received his meal tray at 5:36 p.m. (51 minutes later). | F 658 | Resident #43 and #348<br>Staff #8 and #3 were instructed by DNS on the importance of observing residents swallow pills during medication pass on 07/13/2022. "Resident self administration of Medications" assessments was completed on 08/05/2022 and orders obtained if residents deemed appropriate to self-administer medications after set-up.<br><br>Resident #16<br>Staff #8 was instructed by DNS on the importance of administrating rapid acting insulin 07/13/2022.<br><br>Resident #349<br>Orders were updated and eMAR changed to reflect current order for foley catheter by DNS on 08/04/2022.<br><br>All residents who could self administer medications and residents who receive insulin have the potential to be affected by this deficient practice. | 8/19/22 |

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| F 658 | Continued From page 7<br>During an interview on 07/13/22 at 1:30 p.m., an administrative nurse (#3) stated rapid-acting insulin should be administered 15 minutes before meals.<br><br>- Review of the facility policy titled "Medication Administration" occurred on 07/13/22. This policy, revised April 2021, stated, ". . . Procedure: . . . do not leave medications at the bedside or at the table unless there is a specific physician order to leave the medication with the resident, stay with the resident until the medication is taken and you observe the resident swallow . . ."<br><br>During the evening meal on 07/11/22 at 5:29 p.m., observation showed a nurse (#8) placed Resident #43 and #348's medications in medication cups containing medications on the table next to the residents and failed to observe the residents consume the medications.<br><br>During an interview on 07/13/22 at 01:46 p.m., an administrative nurse (#3) stated Resident #43 and #348 lacked physicians' orders or an evaluation to self-administer medication and she expected staff to stay with the residents until they consumed all the medication.<br><br>2. Based on record review and staff interview, the facility failed to follow professional standards of practice for 1 of 2 sampled residents (Resident #349) reviewed for physicians' orders with a foley catheter. Failure to wrtie a telephone order physician's order may result in adverse consequences to the resident.<br><br>Findings include: | F 658 | Education will be provided by DNS to all licensed nursing staff on accuracy of telephone orders and need to follow through with orders including review of policy "physician/practitioner order" by 08/19/2022.<br><br>DNS will provide education to all licensed nurses on medication pass to include observing resident swallowing the medication and not leaving medications with residents. Policy "Medication Administration including scheduling and Medication Aides" will be reviewed with licensed nurses by 08/19/2022.<br><br>Competency Validation of medication administration to include insulin will be evaluated by learning and education development specialist or DNS by 08/19/2022.<br><br>Medication administration audits to included resident self administration assessments, insulin administration observing residents take their medications (not leaving resident until all medications are consumed) and physician orders will be completed by DNS or appointed RN weekly x4, biweekly x2, monthly x3 then as determined by QAPI committee when compliance is sustained. | |

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| F 658 | Continued From page 8<br>Review Resident #349 medical record occurred on all days of survey. The record showed the facility admitted the resident with an indwelling catheter. On 06/22/22 the facility received a physician's order to remove the indwelling catheter and nursing staff completed the order.<br><br>A "Fax Communication to Physician, "dated 06/27/22, stated, "Came on shift this AM. Resident was in a lot of pain [and] abdomen was distended. Resident stated she had an awful weekend felt like she had to pee all the time.<br><br>Nursing progress notes showed an unidentified nurse called the on call provider and received a verbal order to re-insert the indwelling catheter and get a urine for C&S [culture and sensitivity, a test for urinary tract infection (UTI)].<br>The record showed the indwelling catheter was re-inserted and a urine C& S was completed and sent to the lab.<br><br>The record lacked documentation the facility wrote a telephone order to re-insert the indwelling catheter and obtain a urine sample for C&S.<br><br>During an interview on 07/14/22 at 12:05 p.m., an administrative staff member (#3) confirmed facility staff failed to write a telephone order for Resident #349. | F 658 | | |
| F 726 SS=E | Competent Nursing Staff<br>CFR(s): 483.35(a)(3)(4)(c)<br><br>§483.35 Nursing Services<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure | F 726 | | 8/19/22 |

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| F 726 | Continued From page 9<br>resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br><br>§483.35(c) Proficiency of nurse aides.<br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure nursing staff were able to locate the necessary equipment and how to operate 2 of 3 suction machines (West Unit). Failure to ensure the suction machines were functional and equipment available placed residents at risk for choking and aspiration.<br><br>Findings include: | F 726 | At time of survey, supplies were located immediately and the machines were put together properly prior to end of day.<br><br>Pictures were taken of proper assembly of suction machines and placed in an area where machines are stored to ensure the machines are put together properly. | |

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| F 726 | Continued From page 10<br>Observation on 07/12/22 at 3:36 p.m. showed a supervisory nurse (#3) and two other nurses (#4, and #9) failed to properly set-up and operate the two suction machines located on the West unit.<br><br>During an interview on 07/12/22 at 3:46 p.m., a supervisory nurse (#3) verified the facility nurses failed to locate supplies and properly set-up the suction machines located on the West unit. | F 726 | Both suction machines carts were fully inspected and outdates were completed and Arranged supplies in an organized fashion. Instructions were hung on both suction machine carts.<br><br>Education was provided to nursing staff on 07/18/2022 for properly assembling, operating checking outdates and ensuring suction machines are ready for emergency use at all times. Third suction machine was removed from emergency suction machine cart area and education was provided on 07/18/2022.<br><br>No residents were affected by this practice, residents who may require suctioning may be affected by this practice.<br><br>Suction machine had been used in an emergency and was not properly stored after use. Licensed nurse will be educated by the DNS on the following by 08/19/2022 to ensure that if suction machines are used, they are put back together ready for further use. Nurses will use daily check off sheets to inspect suction machines are functional and ready for use. DNS will oversee this process.<br><br>DNS or appointed licensed nurse will audit ensure suction machines are fully put together, operational and that the proper checks offs have been completed: weekly x4, biweekly x2, monthly x3, then as determined by QAPI committee when | |

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| F 726 | Continued From page 11 | F 726 | compliance is sustained. | |
| F 744 SS=D | Treatment/Service for Dementia<br>CFR(s): 483.40(b)(3)<br><br>§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy, and staff interviews, the facility failed to ensure 1 of 13 sampled residents (Resident #21) who was diagnosed with dementia, received the appropriate treatment and services to attain the highest practicable well-being. Specifically, the facility failed to identify the resident's risk for elopement and implement adequate interventions to ensure the resident's safety. This failure may result in increased behaviors, agitation, and elopement for the residents.<br><br>Findings include:<br><br>Review of the facility policy titled "Elopement" occurred on 07/14/22. This policy, revised 01/12/22, stated, "PURPOSE . . . To clearly define the mechanisms and procedures for monitoring residents at risk for elopement. To provide a system of documentation for the prevention of . . . To Minimize risk for elopement through individualized interventions. . . ."<br><br>Review of Resident #21's medical record occurred on all days of survey. Diagnoses included restlessness, agitation, and dementia. | F 744 | Resident #21 care plan updated to include resident behaviors and agitation and wandering on 8/5/22. Comprehensive review of resident care plan updated 8/19/2022.<br><br>All residents who have a diagnosis or display symptoms of dementia have the potential to be affected by this deficient practice.<br><br>DNS, MDS, and Social Services will identify all residents with a diagnosis of or display symptoms of dementia and will ensure that all care plans are comprehensive, include behavior focus, goals and interventions individualized to each resident by 8/23/22.<br><br>IDT: Monthly behavioral health meeting will be implemented to review all residents with behaviors and residents with diagnosis of dementia starting 8/23/22.<br><br>Education will be provided on 8/24/22 and 8/25/22 to all nursing staff, social services | 8/25/22 |

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| F 744 | Continued From page 12<br>The current care plan stated, "The resident has impaired cognitive function R/T [related to] . . . dementia . . . Wanderguard [alert device]- Secure care at all times for elopement risk. . . ."<br><br>The care plan failed to include specific interventions related to the resident's behaviors and agitation.<br><br>The progress notes showed the following:<br>* 07/01/22 at 2:54 p.m., "Resident attempting to ambulate independently in hallway with unsteady gait. Two assist for safety with one staff pushing w/c [wheelchair] behind resident. Resident became agitated stating he was going uptown to get a beer and attempted to look for a door to go out. . . ."<br>* 07/05/22 at 1:11 a.m., "Resident was up ambulating in halls last evening gait unsteady and refused any cues to use his w/c - set off alarm as he was going to go look for his family . . ."<br>* 07/08/22 at 4:16 p.m., "Resident ambulating independently to door and when staff intervened, stated, that he was going to walk uptown for some booze. Pushed at staff and swore at staff to move out of his way. . . ."<br><br>Observation on 07/12/22 at 1:31 p.m., showed Resident #21 stood at the south hallway door with facility staff present and attempting to redirect the resident. The resident stated he wanted to get the door open so he could go to Minnesota. After 10 minutes, the resident ambulated down the hallway to the north hallway door and stated, "I need to get out that door." Observation showed the resident's gait was unsteady and he refused to allow staff to assist | F 744 | and activities by DNS and Clinical Learning and Development Specialist. This will include policy review of “Dementia Care Guidelines” and “Engaging the Resident with Dementia”<br><br>Computer Based Training course has been assigned to all nursing staff, social services and activities on recognizing behaviors and supporting individuals with dementia to be completed by 8/25/2022.<br><br>Social Worker or designee will complete audits of care plans according to MDS schedule Weekly x4, Bi-weekly x2, Monthly x3, then as determined by QAPI committee until compliance is sustained. | |

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| F 744 | Continued From page 13<br>him with ambulation, use the gait belt, or sit in the wheelchair. After another 5 minutes, Resident #21 ambulated to his room and sat on the edge of his bed.<br><br>During an interview on 07/14/22 at 11:49 a.m., an administrative staff member (#3) confirmed staff failed to implement individualized interventions for elopement for Resident #21. | F 744 | | |
| F 761 SS=D | 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 | F 761 | | 8/19/22 |

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| F 761 | Continued From page 14<br>by:<br>Based on observation and staff interview, the facility failed to properly store medications and laboratory supplies for 4 of 4 storage areas (West and East medication rooms and carts). Failure to discard expired medications, culture swabs and vacutainers (blood specimen collection tubes) and ensure medication refrigerators were free of excessive ice buildup, increases the risk of residents receiving damaged or outdated medications with reduced efficacy and staff utilizing outdated laboratory supplies.<br><br>Findings include:<br><br>-Observation of the West medication room and medication cart occurred on 07/12/22 at 3:36 p.m. with a nurse (#4) and identified the following:<br>* One grey top vacutainer expired 06/30/22.<br>* Four, 20 gauge, one inch Intravenous needles expired 04/30/22.<br>* One 22 gauge, one inch intravenous needle expired 05/31/22.<br>* One suction machine yanker expired 11/01/21.<br><br>-Observation of the East medication room and cart on 07/12/22 at 3:56 p.m. with a nurse (#3) identified the following:<br>*Two boxes of Acid Reducer (generic)10 milligrams (mg) and 20 mg , expired 6/2022.<br>* Medication refrigerator freezer with four to five inches of ice buildup on three sides and condensation on the bottom of the refrigerator. The refrigerator contained two damp boxes of insulin pens.<br><br>During an interview on 07/12/22 at 3:56 p.m., an | F 761 | Lab supplies have been checked for outdates by 07/20/2022. A) Medications have been checked for outdates in med rooms by 07/20/2022..<br>B) Med carts have been checked for outdates by 07/20/2022.<br>C) All supplies, including IV supplies, checked for outdates by 07/20/2022.<br>D) Freezers were defrosted 07/13/2022.<br><br>No residents were affected by this practice.<br><br>Check off sheets for nursing staff will be updated by 08/19/2022 and audits will be performed each month on one section at a time for Week 1 being med carts, Week 2 is med rooms, Week 3 is Lab supplies, Week 4 is all other supplies. Freezers will be defrosted on the 15th of every month.<br><br>Audits will be conducted by DNS/ appointed RN weekly x1 month, biweekly x2 months, monthly x3 months, then as determined by QAPI committee. | |

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| F 761 | Continued From page 15<br>administrative nurse (#3) verified the medication rooms and carts contained expired lab equipment and medications, and ice buildup in the medication refrigerators. | F 761 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; | F 880 | | 8/17/22 |

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| F 880 | Continued From page 16<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which 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; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy, review of professional reference, | F 880 | 1. Corrective Action<br>The facility will immediately implement an | |

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| F 880 | Continued From page 17<br>and staff interview, the facility failed to follow infection control practices for 5 of 17 sampled residents (Resident #17, #20, #21, #40, and #349) observed during cares. Failure to follow infection control practices related to hand hygiene, catheter care, and use of personal protective equipment (PPE), has the potential for transmission of communicable diseases and infections to residents and staff.<br><br>Findings include:<br><br>PERSONAL PROTECTIVE EQUIPMENT<br><br>Review of professional reference found at https://www.cdc.gov/coronavirus/2019-ncov/easy-to-read/mask-guidance.html, updated March 2022, stated, ". . . The mask must cover your nose . . . The mask must be snug on your face . . ."<br><br>Observations on 07/12/22 showed the following:<br>* 11:01 a.m., a certified nurse assistant (CNA) (#2) provided cares for Resident #20 with a surgical mask under her nose.<br>* 10:05 a.m., a CNA (#2) assisted Resident #40 with various requests in his room with a surgical mask under her nose.<br>* 11:12 a.m., a CNA (#2) provided cares for Resident #17 with a surgical mask under her nose.<br>* 1:31 p.m., a CNA (#2) ambulated Resident #21 in the hallway with a surgical mask under her nose.<br>* 3:15 a.m., two CNAs (#1 and #2) exited Resident #349's room with their surgical masks under their nose. | F 880 | appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency.<br><br>The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for:<br>(1) Ensure staff perform hand hygiene when removing gloves, after perineal and incontinent cares, and before exiting a resident's room in accordance with CDC guidelines.<br>(2) Ensure staff perform proper infection control practices when providing catheter cares.<br>(3) Ensure staff continuously wear a surgical face mask, covering both nose and mouth in accordance with guidelines from the CDC.<br>(4) Ensure staff perform proper infection control practices when sharing medical equipment between residents, specifically lifts and commodes.<br><br>2. Identification of Others<br>The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The | |

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| F 880 | Continued From page 18<br>HAND HYGIENE/SANITIZING LIFTS<br><br>Review of the facility policy titled "Hand Hygiene" occurred on 07/14/22. This policy, revised 03/29/22, stated, ". . . PURPOSE . . . To establish hand hygiene as the single most important factor in preventing the spread of disease-causing organisms to patients and personnel in healthcare. . . Patient Zone: . . . contains the patient and their immediate surrounding. Typically includes . . . all inanimate surfaces that are touched by or indirect physical contact with the patient. . . . All employees are responsible for maintaining adequate hand hygiene . . . All employees in patient care areas . . . will adhere to . . . Hand Hygiene. [when] Entering Room, Before Clean Task, After Bodily Fluid/Glove Removal, Exiting Room, Zones . . . Glove use: Change gloves when moving from dirty to a clean . . . performing hand hygiene in between changing gloves. . . . Hand hygiene must be performed after removal regardless of task. . . ."<br><br>Observation on 07/12/22 at 3:10 p.m. showed two CNAs (#1 and #2) applied gloves and transferred Resident #349 onto a bedside commode using a full body lift. The CNA (#2) provided perineal cares. Without changing gloves and performing hand hygiene, the CNA (#2) applied a clean brief, pulled up the resident's pants, transferred her to the bed, and adjusted the blankets. The CNA (#2) then removed her gloves, failed to perform hand hygiene, and placed the lift in a storage room across the hall. The CNA (#1), without removing her gloves, placed the commode in the storage room. The CNAs (#1 and #2) failed to disinfect the lift and the commode after resident use, failed to remove | F 880 | facility will develop action plans to address any newly identified non-compliance.<br><br>3. System Changes<br>On or before 08/17/2022 the facility shall complete the following actions:<br>(1) DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to:<br>a. Failure to complete hand hygiene in accordance with CDC guidelines.<br>b. Failure to ensure staff complete catheter cares in accordance with appropriate infection control practices.<br>c. Failure to wear surgical mask covering nose and mouth.<br>Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf<br>d. Failure to ensure staff disinfect lifts and commodes between residents.<br><br>(2) The DON, IP or suitable designee will ensure the following:<br>a. All staff will receive education on proper hand hygiene after perineal care, after removing gloves and before exiting a resident's room.<br>b. All staff will receive education on proper infection control practices with catheter cares.<br>c. All staff will receive education on the proper use of a surgical mask.<br>d. All staff will receive education on | |

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| F 880 | Continued From page 19<br>gloves after a task, and failed to perform hand hygiene before exiting the room.<br><br>CATHETER CARES<br><br>Review of the facility policy titled "Catheter: Care, Insertion, Removal, Drainage Bags, Irrigation, Specimen" occurred on 07/14/22. This policy, revised April 2022, stated ". . . Catheter Care-Indwelling . . . Provide perineal cares with soap and water . . . Use a clean washcloth . . . to clean the perineal area and the portion of the catheter in contact with the perineum . . . Use a clean section of the washcloth . . . for each stroke. Cleanse away . . . to avoid contaminating the urinary tract. . . . Emptying Catheter Drainage Bag . . . place a moisture resistant barrier beneath the measuring container and avoid placing the container on the floor. . . . Open drainage port and allow urine to drain into measuring container . . . When done, clean drainage port tip with alcohol wipe . . ."<br><br>Observations on 07/12/22 at 11:12 a.m. showed a CNA (#2) emptied Resident #17's catheter bag. The CNA placed a measuring container and an alcohol wipe directly on the floor. The CNA (#2) opened the drainage port, drained the urine into the container, used the alcohol wipe from the floor to clean the drainage port tip, and secured the tip to the catheter bag. The CNA (#2) carried the container to the bathroom, dumped the urine into the toilet, obtained water directly from the sink faucet to rinse the container, and emptied the rinse water into the toilet.<br><br>The CNA (#2) failed to place a barrier under the container, properly disinfect the catheter | F 880 | proper disinfection of medical equipment shared between residents, specifically, lifts and commodes.<br>4. Monitoring<br>Weekly for no less than 12 weeks, the DON, IP, or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include:<br>(1) Observations of certified nursing staff to ensure performance of proper hand hygiene, when indicated, in the course of their routine duties.<br>(2) Observation of certified nursing staff to ensure performance of proper catheter cares.<br>(3) Observation of staff wearing surgical mask in accordance with guidelines for the CDC.<br>(4) Observation of certified nursing staff to ensure performance of proper disinfection practices after using lifts and commodes.<br><br>Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms.<br><br>After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be | |

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| F 880 | Continued From page 20<br>drainage port, and use a clean container in the resident's bathroom sink to obtain rinse water for the measuring container.<br><br>Observation on 07/13/22 at 9:48 a.m., showed two CNA's (#6 and #7) provided perineal and catheter care to Resident #17. The CNA (#6) utilized a washcloth to cleanse bowel movement (BM) from the resident's left groin crease, folded the washcloth, and cleansed around the catheter tube. The CNA placed the washcloth into a basin of soap and water, rinsed the washcloth, and completed perineal cares. The CNA (#6) removed her gloves, and without performing hand hygiene, applied new gloves, and assisted the CNA (#7) to apply a clean brief and pull up the resident's pants. The CNA (#6) removed her gloves, and without performing hand hygiene, left the resident's room, returned with a full body mechanical lift, and assisted the CNA (#7) to transfer the resident into his wheelchair.<br><br>The CNA (#6) failed to follow appropriate infection control practices related to hand hygiene, incontinent care, and catheter care.<br><br>During an interview on 07/13/22 at 5:34 p.m., an administrative staff member (#3) confirmed staff failed to follow proper infection control practices when Resident #17's catheter bag emptied, and perineal and catheter cares provided. | F 880 | reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director.<br><br>5. Correction Date<br>08/17/2022 | |

| 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 _____ | 07/14/2022 |

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

| (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 880 | Continued From page 21<br><br>- Observation on 07/12/22 at 3:10 p.m. showed two CNAs (#1 and #2) applied gloves and transferred Resident #349 onto the bedside commode using a full body lift. The CNA (#2) cleansed the resident, applied a clean brief, pulled up the resident's pants, transferred her to the bed, and adjusted the blankets wearing the same pair of gloves. The CNA (#2) removed her gloves, failed to perform hand hygiene and placed the lift in a storage room across the hall. The CNA (#1) without removing her gloves placed the commode in the storage room. The CNAs (#1 and #2) failed to disinfect the lift and the commode after resident use, failed to remove gloves after a task, and failed to perform hand hygiene before exiting the room. | F 880 | | |