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 _____	10/10/2011

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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on October 3, 2011 and completed on October 10, 2011 the sample included four (4) residents for complete review, ten (10) residents for focused review, and three (3) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to implement its policy to investigate an injury of unknown origin for 1 of 1 sampled resident (Resident #1) with an injury of unknown origin. Failure to investigate this injury placed Resident #1 and all facility residents at risk of injury. Findings include: Review of the facility policy and procedure, "Abuse and Neglect" occurred on 10/05/11. This document, revised January 2009, stated "POLICY . . . Alleged or suspected violations involving . . . injuries of unknown origin . . . The center/campus will have evidence that alleged or suspected violations are thoroughly investigated . . ."	F 226	- Resident # 1 expired on 10/6/2011. - All residents have the potential to be affected by this deficient practice. - The incident committee will investigate every incident of injury of unknown origin for potential abuse and neglect. Staff in-service will be held 11/9/2011 to instruct how to investigate incidents when completing an incident report. The unit coordinators and/or their designee will investigate any incidents of unknown origin and report to the incident committee.	

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

David Cauda | Administrator | 11-1-11

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
	355095	A. BUILDING _____ B. WING _____	10/10/2011

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 226	Continued From page 1 Review of Resident #1's medical record occurred on October 03-05, 2011. The facility admitted the resident in July 2011. Current diagnoses included subdural hematoma post fall (pre-admission), post craniotomy, and weakness. The resident's admission Minimum Data Set (MDS), dated 07/15/11, identified the resident sometimes made himself understood and sometimes understood others, identified short term memory problems, and required extensive assistance of two or more persons for bed mobility and transfers. Resident #1's current care plan, dated 09/15/11, stated "Problems . . . Alteration in mobility and muscle strength r/t [related to]: recent pneumonia et [and] h/o [history of] subdural hematoma m/b [manifested by] decreased functional abilities . . . Plans . . . Transfer with assist x [times] 1, may use 2 assist prn [as needed] as condition indicates. No unsupervised activities . . . Assist bars x 2 to aid in repositioning . . ." Resident #1's Daily Skilled Note (nurse's notes), dated 09/16/11 at 6:30 p.m., stated "Noted a reddened, slightly raised bump to left side of head. See [Incident Report]. Neuro [Neurological] checks in progress." The resident's Incident Report, dated 09/16/11 at 6:30 p.m., stated "Date Incident Occurred: Unknown . . . D. Contributing Factors: . . . Comments: Noted reddened bump on left side of his head. Slight swelling noted. Resident states "ow" when site palpated. . . . E. Part of Body Allegedly Injured: . . . Did resident hit his/her head? Yes . . ." Resident #1's medical record identified neurological checks were unchanged from	F 226	- An audit will be developed to show compliance of investigations of every incident of injury of unknown origin for potential abuse or neglect. Audits will be done by QA Coordinator and/or designee weekly for 1 month, monthly for 3 months and then as deemed necessary by the QI committee. - Completion Date 11/14/2011.	11/14/2011

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 _____	10/10/2011

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 226	Continued From page 2 previously and considered "within normal limits." During interview, on 10/05/11 at 1:45 p.m., a supervisory nursing staff member (#4) reported the facility did not complete an investigation of Resident #1's injury of unknown origin. This staff member (#4) and an administrative nursing staff member (#3) reported the facility staff attributed the bump, swelling, and Resident #1's pain to a "bleed" related to his subdural hematoma. These staff members provided no additional information, as requested during the interview, regarding Resident #1's injury on 09/16/11. Resident #1 did not engage in unsupervised activities and required assistance for bed mobility and transfers. The facility failed to investigate the injury to Resident #1's head which resulted in the resident experiencing swelling, redness, and pain. This failure placed Resident #1 and all facility residents who required assistance with mobility at risk of injury.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy, the facility staff failed to provide 1 of 6 sampled residents (Resident #14) and 1 of 2 supplemental residents (Resident #19) cueing and assistance during meals during 4 of 5 meal	F 241	- Residents # 14 and #19 will continue to be able to feed themselves with staff cueing and assistance when needed to maintain dignity and independence. - All residents who independently feed themselves are at risk to be affected by this deficient practice.	

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 _____	10/10/2011

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 241	Continued From page 3 observations. Failure to provide the necessary assistance when residents dropped meal items on their clothing protectors and/or on the table and then ate those items did not recognize or enhance the dignity of these residents. Findings include: The facility policy titled "Resident-Assisted Dining", revised 11/09, stated, ". . . 5. Encourage resident in feeding self, assisting as needed . . . 7. Have resident wipe lips and clean face, as necessary and able . . ." Observations in the facility's assisted dining area identified the following: Resident #14 - *10/04/11, 12:00 noon - The resident seated in a wheelchair at a dining room table with three other residents and one unidentified staff member. The resident independently ate a piece of pie, dropped some of the pie on her clothing protector, picked the pie off her protector with her fork or fingers, and ate it. The staff member commented to the resident "pie good." The resident continued to eat the entire piece of pie and the staff member failed to provide cueing or assistance to Resident #14. *10/05/11, 8:00 a.m. - The resident seated in a wheelchair at a dining room table with three other residents, one unidentified staff member, and a certified nursing assistant (CNA) (#1). The resident independently ate cold cereal, dropped some of the cereal on her clothing protector, picked the cereal off her protector with her fingers, and ate it. The CNA (#1) commented to the resident "hungry." The resident continued to	F 241	- Staff in-service will be held 11/9/2011 to alert staff to be more observant when a resident is eating to check if the resident needs more assistance and/or cueing. - An audit will be developed to show compliance of needed cueing and assistance offered to residents who feed themselves. Audits will be done by QA Coordinator and/or designee weekly for 1 month, monthly for 3 months and then as deemed necessary by the QI committee. - Completion Date 11/14/2011	11/14/2011

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 _____	10/10/2011

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 241	Continued From page 4 eat the cereal and the staff members failed to provide cueing or assistance to Resident #14. *10/05/11, 11:40 a.m. - The resident seated in a wheelchair at a dining room table with three other residents. A CNA (#5) assisted a resident seated next to Resident #14. The resident independently ate pudding from a cup using a spoon. A large amount of drool formed from the left side of her mouth to her chin, and dripped onto her clothing protector. She sat at the table for more than four minutes prior to the CNA (#5) cueing her to wipe her face. After finishing the pudding, Resident #14 used her clothing protector as a Kleenex, blowing/wiping her nose three times. The CNA (#5) failed to offer the resident a Kleenex or clean clothing protector. After staff delivered her tray to the table, Resident #14 independently ate jello from a small bowl using a spoon. Again, a large amount of drool formed from the left side of her mouth to her chin. She sat at the table for more than two minutes prior to wiping her face. The CNA (#5) failed to provide cueing. After finishing her jello, Resident #14 began to eat other food items from her plate. Several pieces of cabbage fell from her fork and/or from the left side of her mouth, to the chest area of her clothing protector. The resident began poking her clothing protector and the top of the table with her fork, attempting to locate the missing cabbage. The CNA (#5) failed to provide cueing, and eventually the resident returned her attention back to her plate. At the end of the meal, the resident sat at the table with four pieces of cabbage on her clothing protector. The CNA (#5) failed to provide cueing and/or remove the cabbage. Resident #19 - *10/04/11, 8:00 a.m. - The resident seated in a	F 241		

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 _____	10/10/2011

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 241	Continued From page 5 wheelchair, at a dining room table with two other residents. An unidentified staff member assisted a resident seated across the table from Resident #19. Resident #19 independently ate a fried egg, pushed pieces of the egg off the plate, onto the table, picked up the pieces of egg off the table, and ate them. The staff member commented to the resident "like eggs." The staff member failed to provide cueing or assistance to Resident #14. During interview, on 10/05/11 at 2:00 p.m., a supervisory nursing staff member (#2) reported staff should provide Resident #14 and #19 cueing and assistance with meals when necessary. An administrative nursing staff member (#3) and staff member (#2) agreed the staff members should have assisted these residents during the meal observations previously identified.	F 241		
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 record review, review of facility policy and procedure, review of professional reference, and staff interview, the facility failed to ensure 1 of 4 sampled residents with insulin dependent diabetes (Resident #5) received the care and services necessary regarding physician	F 309	- The parameter for blood sugar levels for resident #5 was ordered by his/her medical provider on 10/27/11. - All diabetic residents have the potential to be affected by this deficient practice.	

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 _____	10/10/2011

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 309	Continued From page 6 notification for low blood sugars (hypoglycemia). Failure to contact the physician placed Resident #5 at risk of complications and limited the physician's ability to ensure the quality of care. Findings include: Review of the facility policy and procedure, Blood Glucose Monitoring, occurred on 10/05/11. This document, revised January 2009, stated "PURPOSE, To accurately monitor resident's level of blood glucose. To maintain control of diabetic condition. . . . NOTES, The physician's orders should include blood glucose high and low parameters and when to notify the resident's physician. . . . PROCEDURE . . . 11. Notify physician if necessary per parameters." The internet site for the National Institutes of Health, National Diabetes Information Clearinghouse, www.niddk.nih.gov, states "Diabetes related Hypoglycemia . . . To treat hypoglycemia, people should have a serving of a quick-fix food, wait 15 minutes, and check their blood glucose again. . . . If the level is below 70 mg/dL, one of these quick-fix foods should be consumed right away to raise blood glucose . . . fruit juice . . . milk . . ." Review of Resident #5's medical record occurred on October 03-05, 2011. The facility admitted the resident in September 2003. The resident's current diagnoses included diabetes mellitus and dementia. The resident's physician orders, initiated on 02/26/11 and renewed on 08/16/11, included "Humulin [Insulin] 70/30, 36 units subq [subcutaneously] every AM [morning]" and "Accucheck BID [two times each day] . . . twice a	F 309	- All residents that have blood glucose monitoring have parameters in place that were ordered by their medical provider. Nursing will be educated on 11/3/2011 to recognize and document low blood glucose levels, provide snacks, recheck the blood glucose level and to notify the medical provider when indicated. - An audit will be developed to show compliance that when a blood glucose level tests low, the resident is provided a snack, blood glucose is rechecked, and the medical provider is notified if indicated. The audit will be done by QA Coordinator and/or designee weekly for 1 month, monthly for 3 months and then as deemed necessary by the QI committee. - Completion Date 11/14/2011	11/14/2011

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 _____	10/10/2011

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 309	Continued From page 7 week . . ." The physician's orders lacked blood glucose high and low parameters and when to notify the resident's physician. Resident #5's Accucheck record, for the months of June through September 2011, identified the following blood glucoses and the facility staff's actions: *06/13/11, 5:00 a.m. - 57 [milligrams per deciliter (mg/dl)], juice given. *06/30/11, 5:00 p.m. - 57 mg/dl, no action. *07/07/11, 5:00 p.m. - initialed, as completed, and no level recorded. *07/11/11, 5:00 a.m. - 66 mg/dl, milk given. *07/11/11, 5:00 p.m. - initialed and no level recorded. *07/18/11, 5:00 p.m. - 67 mg/dl, snack given. *07/21/11, 5:00 p.m. - 52 mg/dl, no action. *08/08/11, 5:00 a.m. - 60 mg/dl, snack given. *09/08/11, 5:00 p.m. - initialed and no level recorded. *09/22/11, 5:00 p.m. - initialed and no level recorded. Resident #5's physician extender progress note, dated 08/16/11, stated ". . . He has Accu-Cheks [sic] done b.i.d. several times a week. His a.m. ranges from 68 [mg/dl] to 126 [mg/dl] and evening range from 68 [mg/dl] to 193 [mg/dl] depending on his appetite. . . ." The physician extender's progress note lacked information regarding the blood glucose levels less than 68 mg/dl. During interview on 10/05/11 at 1:45 p.m., an administrative nursing staff member (#3) and a supervisory nursing staff member (#4) confirmed Resident #5 lacked physician orders for blood	F 309		

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 _____	10/10/2011

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 309	Continued From page 8 glucose parameters and when to notify the physician regarding blood glucose levels. These staff members also agreed facility staff should record blood glucose levels when measured. The facility staff failed to record blood glucose levels when measured; failed to provide a snack in response to low blood glucose levels; failed to re-check the blood glucose levels after low measurements; and failed to ensure parameters for high and low blood glucose levels and when to notify the physician. Resident #5's medical record and the physician extender's progress note lacked evidence the staff notified the physician or extender regarding the low blood glucose levels. These failures placed Resident #5 at risk of hypoglycemic episodes, complications related to hypoglycemia, and limited the physician's ability to ensure the quality of resident care.	F 309		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of 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.	F 431	- No residents were directly affected by this deficient practice. - All residents have the potential to be affected by this deficient practice.	

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 _____	10/10/2011

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 431	Continued From page 9 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional literature, policy and procedure review, record review, review of manufacturer's instructions, and staff interview, the facility failed to store all drugs and biologicals under proper temperature controls in 2 of 2 medication refrigerators (East and West Medication Room). Failure to maintain the temperature within an acceptable range has the potential to affect the potency and efficacy of the medication. Findings include: Diabetes Care by the American Diabetes Association, Inc., January 2004, Vol. 27, Supplement 1, stated, ". . . Insulin Administration. . . Storage. . . Extreme temperatures ([less than] 35 [degrees Fahrenheit]) should be avoided to	F 431	- The med room refrigerators were cleaned and defrosted on 10/15/2011. New thermometers were ordered on 10/26/2011. A new log sheet was developed to make the documentation of temperature checks easier to understand. The DNS is to be notified of any out-of-range temps. This procedure will be implemented on 11/1/2011. Nursing education will be done on 11/3/2011 regarding documentation of med room refrigerator temperatures on the new log sheet, when to make temperature adjustments, and to report abnormal temperature readings outside of the normal range of 36 to 46 degrees Fahrenheit, which may affect the potency and efficacy of the medications. - An audit will be developed to show compliance that the refrigerator temperatures are within their normal range, temperature adjustments are made as needed and reporting is done when necessary. The audit will be done by QA Coordinator and/or designee weekly for 1 month, monthly for 3 months and then as deemed necessary by the QI committee. - Completion Date 11/14/2011	11/14/2011

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 _____	10/10/2011

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 431	Continued From page 10	F 431		

prevent loss of potency, clumping, frosting, or precipitation. Specific storage guidelines provided by the manufacturer should be followed. . . ."

Review of the facility procedure titled "Acquisition, Receiving and Dispensing of Medications" occurred on 10/05/11. The procedure, dated May 2011, stated ". . . 6. Refrigerators holding medications (such as insulin, etc.) will be kept at 36-46 degrees F [Fahrenheit]. . . ."

- Review of the facility form titled "Refrigerator/Freezer Temperature Log" for the East medication room for the months of July - October, 2011 occurred on the afternoon of 10/05/11. Each form contained the note ". . . Medications: Refrigerators must be between 36-46 [degrees] F. . . ." and showed the following:
* 29 degrees F on 1 day (August 21)
* 30 degrees F on 4 days (July 14, August 13, 20, 23)
* 31 degrees F on 2 days (August 7 and 22)
* 32 degrees F on 15 days (July 10, 23-24, 26, 29-30, August 11-12, 14, 16-19, 28, September 25)
* 34 degrees F on 19 days (July 2-3, 7-9, 11, 17-19, 22, 25, 28, 31, August 2-3, 8, 10, 15, 26)
The temperature log showed staff adjusted the refrigerator thermostat on 6 of the 41 days the temperature fell below 36 degrees.

On 10/05/11 at 3:55 p.m., observation showed the following medications in the East medication room refrigerator:
* Box of Acetaminophen 650 milligram (mg) suppositories; Semla, Beizer, Higbee, "Geriatric Dosage Handbook," 12th ed., Lexi-Comp, Inc., Ohio, page 28, states regarding Acetaminophen,

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 _____	10/10/2011

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 431	Continued From page 11 ". . . Stability: Do not freeze suppositories. . . ." * Box of Anucort-HC (hydrocortisone) 25 mg suppositories - labeled "Store between 59-86 degrees F. Protect from freezing." * Box of Fluarix influenza virus vaccine - labeled "Store between 36-46 [degrees] F. Do not freeze." * Vial of pneumococcal vaccine - labeled "Store 36-46 [degrees] F." * One box each of Risperdal Consta 50 mg and 37.5 mg for intramuscular (IM) injection - labeled "Store in refrigerator . . . 36 degrees F to 46 degrees F . . . Protect from freezing." - On the afternoon of 10/05/11, review of the Refrigerator/Freezer Temperature Logs for the West medication room, for the months of September and October 2011, showed the following: * 32 degrees F on 15 days (September 8, 10-13,15,17-25) * 34 degrees F on 2 days (September 14 and 27 * 35 degrees F on 2 days (September 28 and October 2) The logs failed to identify any action taken when the temperatures dropped below the range of 36-46 degrees F. Observation of the West medication room refrigerator, at 3:10 p.m. on 10/05/11, showed the following medications in the refrigerator: * 1 vial of pneumococcal vaccine - labeled "store 36-46 [degrees] F." * 7 vials of lorazepam injection - labeled "store in refrigerator 36 to 46 [degrees] F." * 30 pouches of Brovana inhalation solution - labeled "store unopened pouches . . . in a refrigerator 36-46 [degrees] F."	F 431		

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 _____	10/10/2011

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 431	Continued From page 12 * 20 vials of influenza virus vaccine fluvirin - labeled "store between 36-46 [degrees] F." * 2 vials of Lantus insulin - labeled "store refrigerated 36-46 [degrees] F. Do not freeze. Discard vial if frozen." * 1 vial of Humulin 70/30 insulin - labeled "refrigerate do not freeze." During an interview the afternoon of 10/05/11, an administrative nurse (#4) agreed staff should keep the medication refrigerator temperature should be kept between 36-46 degrees F.	F 431		