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 _____	C 05/24/2017

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 and complaint survey, started on 05/22/17 and completed on 05/24/17, the sample included 3 residents for complete review, 9 residents for focused review, and 1 closed record for review. The sample included an additional 5 supplemental residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for	F 156		7/7/17

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

Electronically Signed | 06/16/2017

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 _____	C 05/24/2017

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 156	Continued From page 1 Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)	F 156		

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 _____	C 05/24/2017

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 156	Continued From page 2 [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office,	F 156		

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 _____	C 05/24/2017

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 156	Continued From page 3 adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with	F 156		

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 _____	C 05/24/2017

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 156	Continued From page 4 the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 156		

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 _____	C 05/24/2017

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 156	Continued From page 5 Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A notices/files and staff interview, the facility failed to provide adequate written notices for 4 of 4 residents (Resident #15, #16, #17, and #18) reviewed for termination of Medicare coverage. Failure of the facility to provide notices that contained the correct contact information for the Fiscal Intermediary (FI)/Medicare Administrative	F 156	1. This plan of correction will not affect Residents #15, #16, #17, #18 as they have been previously discharged. All Medicare Part A residents upon discharge will receive a SNF determination of Continued Stay form with the full name, address and phone number for the Fiscal Intermediary Medicare Administrative	

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 _____	C 05/24/2017

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 156	Continued From page 6 Contractor (MAC) limits the residents' ability to exercise their rights related to Medicare Part A. Findings include: Review of Medicare Part A denial notices occurred on 05/23/17 at 3:05 p.m. The facility's SNF (Skilled Nursing Facility) Determination on Continued Stay (denial) form failed to contain the FI/MAC's (Noridian Healthcare Solutions) address. The following denial forms failed to have the contact name's address. * Resident #15 - signed on 12/23/16 * Resident #16 - signed on 01/30/17 * Resident #17 - signed on 01/16/17 * Resident #18 - signed on 05/10/17 During the review of the denial notices, an office manager (#15) stated she was unaware the denial forms required an address for Noridian.	F 156	Contractor. 2. All residents with Medicare A benefits have the potential to be affected by this deficient practice. 3. The licensed Social Services Director, was reeducated on the address requirement on the 2-day Medicare Part A notices by the surveyor on May 23, 2017. The address for Noridian Healthcare Solutions is now included on all 2 day notices as well as the contact phone number. 4. QA coordinator or designee will audit denial notice forms for complete Noridian contact information weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters or as deemed necessary by QAPI committee. Audit results will be submitted to the QAPI for review and further recommendations.	
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 157		7/7/17

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 _____	C 05/24/2017

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 157	Continued From page 7 mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure notification of a health	F 157	1. Resident #3 has not voiced any further suicidal comments since that event.	

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 _____	C 05/24/2017

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 157	Continued From page 8 care provider for 1 of 1 sampled resident (Resident #3) who experienced a change in mental health status. Failure to notify the resident's health care provider of thoughts of suicide may have resulted in further decline and may affect the resident's quality of life. Findings include: Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia with behaviors, psychosis, anxiety and depression. The quarterly Minimum Data Set (MDS), dated 07/18/16, identified severe impaired cognition and the mood indicators showed the resident thought she would be better off dead on two to six days during the 7-day look-back period. The care plan stated, "Focus: The resident is on antidepressant medication therapy. . . . Interventions: Monitor for increased risk for falls (revised 04/19/16) . . . Focus: The resident has a mood problem R/T [related to] anxiety, restlessness, major depression, psychosis E/B [evidenced by] mood fluctuates. . . . Interventions: think better dead: reassure. SW [social worker] or nurse contact Pastor at her request (revised 07/19/16). . . ." Review of Resident #3's progress notes identified the following: *07/20/16 at 4:49 a.m.: "upon rounding on resident. resident still awake sitting in recliner. resident is holding scissors in her hand. when asked what she is doing with the scissors, resident states, 'I'm going to cut my throat.' and held scissors up to her throat. This nurse and	F 157	2. All residents have the potential to be affected by this deficient practice. 3. Nursing staff will be educated with the Suicide Precaution procedure, Suicide Risk Assessment and on Notification of physician and to document what was told to the physician on June 29, 2017 or before their next schedule shift by the Director of Nursing or designee. 4. QA coordinator or designee will audit progress notes and other means of communication for any residents with suicidal comments weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters or as deemed necessary by QAPI committee. Audit results will be submitted to the QAPI for review and further recommendations.	

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 _____	C 05/24/2017

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 157	Continued From page 9	F 157		

CNA [certified nursing assistant] was able to get scissors out of her hands. suicide precautions started. removed all sharp objects from room, including all items that could cause self-injury. resident refused to come up to nurses station where we could monitor her. so monitoring every 10 minutes was initiated. resident is sitting in her recliner calm in her room. will notify physician and administration of event."
*07/20/16 at 6:26 a.m.: ". . . told [Resident #3's daughter] about incident with scissors. . . . told her we will be calling the doctor this morning for further orders and instruction . . ."

A "FAX COMMUNICATION TO PHYSICIAN" form, dated 07/20/16 at 7:20 a.m., and faxed to the Physician Assistant (PA), stated, ". . . Concern: Resident has been more confused, restless & agitated in the past 48 hrs [hours]. Family would like a UA [urinalysis] done. Could we please get an order? What do you suggest? . . . Physician comments/non-medication orders: UA . . ."

The documentation lacked evidence facility staff notified the physician regarding Resident #3's suicidal comments.

A progress note, dated 07/20/16 at 8:30 a.m., stated, ". . . Informed [Resident #3's daughter] resident was yelling and screaming during breakfast, daughter could hear resident yelling. Resident wants to go home. UA obtained-UA normal. PRN [as needed] xanax [antianxiety medication] ordered by [psychiatrist]."

During an interview on 05/23/17 at 3:25 p.m., an administrative nurse (#1) confirmed staff failed to

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 _____	C 05/24/2017

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 157	Continued From page 10 update Resident #3's health care provider on her suicidal comments.	F 157		
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by:	F 221		7/7/17

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 _____	C 05/24/2017

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 221	Continued From page 11 Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess and/or obtain a physician's order for the use of a restraint for 2 of 2 sampled residents (Resident #6 and Resident #9) observed with a seat belt or gait belt while in a wheelchair. Failure to complete the necessary assessment and/or obtain a physician's order prior to the placement of a seat belt (Resident #6) or leg strap (Resident #9) while seated in a wheelchair placed the resident at risk for injury. Findings include: Review of the facility policy titled "Physical Restraints" occurred on May 24th, 2017. This policy, revised November 2016, stated, ". . . Physical Restraints - any manual method or mechanical device, material or equipment attached or adjacent to the resident's body . . . Anytime a device, material or equipment is attached or placed adjacent to the resident's body, a determination will be made by a licensed nurse as to whether it is or could be a restraint for the individual resident. . . . If the device, material, or equipment is not a restraint for this resident, then the steps taken to make this decision must be documented in PN [Progress Notes] - Psychopharmalogical Med [medication]/Physical Restraint. If the device, material or equipment is not a restraint, it must be reviewed with a significant change in condition and quarterly in conjunction with the care plan to ensure that it continues to not be a restraint for the resident. . . . Non-Emergency Restraint Use 1. Prior to the application of a non-emergency physical restraint, the following must be completed: a. There must be documentation in	F 221	1. Resident #6 has been assessed using the Physical Restraint Assessment on June 6, 2017 and found he no longer needs the wheel chair seat belt alarm and it was removed. Resident #9 received order May use leg straps to secure legs during use of immobility device and strap has been identified on the mobility device assessment. 2. All residents who utilize a seatbelt or other positioning devices have the potential to be affected by this deficient practice. 3. Nursing staff will be reeducated on the procedure Application of Physical Restraint on June 29, 2017 or their next schedule shift, to ensure knowledge of the procedure before and during the use of a seating and positioning device by the Staff Development Coordinator or designee. 4. QA coordinator or designee will audit order for any residents with safety and mobility devices, weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters or as deemed necessary by QAPI committee . Audit results will be submitted to the QAPI for review and further recommendations.	

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 _____	C 05/24/2017

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 221	Continued From page 12	F 221		

the PN-Psychomaracological Med/Physical response to previous interventions attempted. b. Each location will need to designate a committee that reviews restraint use. . . . e. There will be documentation in the medical record of the resident's response to these new interventions and ongoing re-evaluation of the need for the restraint. . . . 2. . . . If . . . a restraint may be needed, the following must be completed: a. The registered nurse will complete the designated portions of the Physical Device and Restraint Assessment . . . b. The interdisciplinary care team or the reduction committee will review the assessment. The team may want to involve physical and/or occupational therapy in this process. c. Contact the physician and describe the rationale, alternatives tried and recommendations. d. Obtain a physician's order for the appropriate restraint, times to be used and the medical symptom for use. e. Obtain informed consent using the Permission for Use of Physical Restraints . . . . If the resident is unable to provide consent, documentation must be completed stating the reason. Permission will be obtained from a person authorized to sign for the resident. f. Update the resident care plan to include the reason for the restraint, the required monitoring and a measurable goal relating to the rationale for its use. . . . h. Be certain that the physician's order, the Physical Device and Restraint Assessment . . ., the Permission for Use of Physical Restraints, and the care plan all match for type of restraint use, when it will be used, and how often it is to be released. . . ."

- Review of Resident #9's medical record occurred on 05/24/17. Diagnoses included disease of spinal cord and history of polio. The

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 _____	C 05/24/2017

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 221	Continued From page 13	F 221		

quarterly MDS, dated 05/01/17, identified intact cognition, extensive assistance of two or more people required for bed mobility, transfers, and dressing, and extensive assistance of one person required with toilet use and personal hygiene, and no falls or physical restraints. The current care plan stated, "Focus: The resident has limited physical mobility R/T Disease process (h/o [history of] polio) EB left sided weakness . . . Interventions: MOBILITY: Uses motorized scooter with leg strap due to abduction (Date Initiated: 09/24/2014). . . ."

Observation throughout the survey showed Resident #9 seated in his electric wheelchair with a gait belt secured around his thighs, holding his legs together.

Review of the "Motorized Mobility Device Assessment" dated 09/24/14 stated, ". . . 8. Level of Assistance Needed/Comments 1. Please indicate level of assistance with any of the above and any additional comments: Patient requires assitance [sic] for transfer on/off of w/c [wheelchair]. Patient will require assistance lifting bottom off of seat to pull down/up pants. Patient requires assitance [sic] taking w/c in/out of gear. Patient educatated [sic] on leaving w/c in slowest setting. Patient does not plan to go outside of building except for padio [sic] area with w/c. Dressing stick hung on door to assist with opening and closing of door for exiting of room . . ." The "Motorized Mobility Device Assessment" failed to identify Resident #9's leg strap.

Review of the progress notes showed the following:
*09/24/14 at 12:30 p.m.: "Name the individual(s)

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 _____	C 05/24/2017

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 221	Continued From page 14	F 221		

who received education and describe any barriers to learning: [Resident #9] no barriers Focus/topic of teaching . . . w/c management Teaching methods . . . patient participation Outcome of teaching . . . verbilizes [sic] and demonstrates understanding Evaluation of teaching . . . independent with electic [sic] w/c use"
*09/25/14 at 1:26 p.m.: "OT [occupational therapy] eval [evaluation] completed . . . Resident is is [sic] appropriate to safely operate electric W/C. See eval for more info."

The physician orders failed to identify Resident #9's leg strap.

During an interview on 05/24/17 at 11:00 a.m. an administrative nurse (#1) confirmed facility staff failed to assess Resident #9's leg strap as a restraint.

The facility failed to complete an initial assessment and quarterly assessments of Resident #9's leg strap and failed to continuously monitor the use of the leg strap.

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included history of falls and dementia. The quarterly Minimum Data Set (MDS), dated 03/20/17, identified moderately impaired cognition, extensive assist of two people with bed mobility, transfers, dressing, personal hygiene, and toileting, one fall with no injury, and no physical restraints. A physician order, dated 05/25/16, stated "Self releasing w/c [wheel chair] belt with alarm when up in chair per OT

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 _____	C 05/24/2017

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 221	Continued From page 15	F 221		

[occupational therapy] recommendation." The current care plan stated, ". . . The resident is at risk for falls R/T [related to] deconditioning E/B [evidenced by] History of falls. Fall from w/c on 03-20-17. No injury. . . . Interventions . . . Self releasing w/c belt with alarm when up in chair per OT recommendation. Staff to check frequently that w/c belt is fastened. . . ."

Review of the Occupational Therapy OT Evaluation & Plan of Treatment, dated 05/25/16, stated ". . . Reason for Referral: Pt [patient] is a long term resident of this facility and was referred to OT following several falls from w/c. . . . Falls Pt has recent fall or hx [history] of falling out of chair = No (Nursing reports pt with recent falls from w/c during behavioral episodes. Good posture noted for this date, with no concerns of slipping/falling from w/c. Pt able to reposition self independently as needed for comfort) . . . Restraint Used = Yes (Pt currently using w/c seatbelt. Pt is able to open/close belt independently.) ; Restraint restricts movement/limits = Yes; restraint release schedule is in place = Yes. . . ."

Observation on 05/22/17 at 3:56 p.m. showed Resident #6 seated in his wheelchair at the nursing station with a seat belt fastened around his waist.

Observation on 05/23/17 at 9:11 a.m. showed Resident #6 in his room seated in his wheelchair with a seat belt fastened around his waist.

Observation on 05/23/17 at 3:20 p.m. showed Resident #6 seated in his wheelchair at the nurse station with a seat belt fastened around his waist.

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 _____	C 05/24/2017

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 221	Continued From page 16 During an interview on 05/23/17 at 2:00 p.m., an administrative nurse (#1) stated the facility lacked assessments for Resident #6's seatbelt use and documentation to show monitoring of the seat belt use. The facility failed to assess and document the continuous monitoring of the seatbelt use.	F 221		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities 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. (c) In response to allegations of abuse, neglect,	F 225		7/7/17

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 _____	C 05/24/2017

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 225	Continued From page 17 exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, staff interview, and resident and family interview, the facility failed to thoroughly investigate and	F 225	1. An incident report was completed and investigated on May 23, 20-17 on Resident #3. Resident #8 has not	

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 _____	C 05/24/2017

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 225	Continued From page 18 report an incident of potential neglect and an injury of unknown origin for 2 of 2 sampled residents (Resident #3 and #8). Failure to investigate an incident of neglect (Resident #8 received the wrong medication) and an injury of unknown origin (Resident #3) placed all residents at risk for abuse and/or neglect, and did not allow the facility to determine causative factors for the incident/injury and implement corrective actions. Findings include: Review of the facility policy titled "Abuse and Neglect" occurred on 05/24/17. This policy, revised October 2016, stated, ". . . Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator and to other officials in accordance with state law, including the state survey and certification agency. . . . The location will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress. Results of all investigations will be reported to the administrator or designated representative and to other officials in accordance with state law, including to the state survey and certification agency within five working days of the incident, or sooner as designated by state law. If the alleged or suspected violation is verified, appropriate corrective action will be taken. . . . If there is an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source . . . and/or there is serious bodily injury, than [sic] it will be reported not later than two hours after the allegation is made to the	F 225	received any further incorrect medications. 2. All residents have the potential to be affected by abuse and/or neglect. 3. Nurses and Medication Aids will be educated on Abuse and/or Neglect, and the procedures of Medication Administration and Medication Error procedures and reports by a Registered Nurse Educator or designee, for our community on June 29, 2017 or by their next scheduled shift. 4. QA coordinator or designee will audit progress notes and incident reports for the potential of abuse and/or neglect and observation of medication administration to ensure the 5 rights are being observed weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters or as deemed necessary by QAPI committee. Audit results will be submitted to the QAPI for review and further recommendations.	

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 _____	C 05/24/2017

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 225	Continued From page 19	F 225		

administrator, and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care centers) in accordance with state law. . . . If, as a result of a survey, a location receives a citation under abuse and neglect for an incident that was not previously investigated, then the location will treat this citation as an allegation and proceed with all of the steps as outlined above. . . ."

- Review of Resident #8's medical record occurred on all days of survey. Diagnoses included heart failure, urinary tract infection (UTI), hypertension, anxiety disorder, and macular degeneration. A quarterly Minimum Data Set (MDS), dated 04/25/17, identified intact cognition.

Review of the progress notes identified the following:
* 04/18/17 6:40 p.m. - "CNA [certified nursing assistant] summoned nurse into resident's room. Found resident slumped over on bed on her left side. Resident mumbling and very lethargic. Unable to tell me what is wrong . . . No response when asked if having chest pain . . [Physician] notified and orders received to send to ER [emergency room] for evaluation."
* 04/20/17 4:20 p.m. - "Resident returned with staff from [hospital] with dx [diagnoses]: altered mental status and UTI. . . ."
* 04/24/17 4:00 a.m. Late Entry - Res [resident] went to the clinic today for a follow-up after recent hospitalization. Family did go along and later afternoon brought to Administrator's attention a lab value of concern. DNS [Director of Nursing Services] called hospital and the lab

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 _____	C 05/24/2017

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 225	Continued From page 20	F 225		

report was faxed to the facility. Incident report initiated."

Resident #8's hospital admission history and physical (H&P), dated 04/18/17, stated, ". . . Quite sedated . . . Altered mental status, question etiology [cause], assess urine drug screen." The hospital discharge summary, dated 04/20/17, stated, ". . . According to nursing home records and report, the patient was found unresponsive while on rounds . . . reported to ED [emergency department]. At that time though she did have her eyes open not to commands, but was very sleepy and nonverbal . . . Urine drug screen was ordered, that is still pending. I did have a long conversation with the patient on discharge about possibility of medication mixup at the nursing home as . . . roommate is on benzodiazepines. . . ."

Review of urine toxicology report, dated 04/19/17, identified positive for "Tricyclics" (anti-depressant) and "Benzodiazepines" (anti-anxiety).

During an interview on 05/23/17 at 8:45 a.m., Resident #8 indicated about a month ago she had been admitted to the hospital due to staff administering the wrong medications.

During an interview on 05/23/17 at 3:50 p.m. and on 05/24/17 at 8:15 a.m., an administrative nurse (#1) stated the following:
* Resident #8's medication error occurred on 04/18/17
* Facility staff were unaware of the medication error until 04/24/17 after the resident's family brought the urine toxicology results to the

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 _____	C 05/24/2017

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 225	Continued From page 21 Administrator's attention * Facility staff failed to review the hospital's admission H&P or discharge summary when the resident returned on 04/20/19 or request the urine toxicology screen * Facility staff failed to investigate to determine whose medication or what medication(s) Resident #8 received * Facility staff completed only one staff interview (certified nursing assistant/certified medication aide (CNA/CMA) on duty during the medication error) * The facility failed to communicate and educate all nurses regarding the medication error * The facility failed to report the incident to the State Survey Agency within the required timeframe and submit the follow-up report within 5 days - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dementia with behaviors. A significant change MDS, dated 03/10/17, identified severely impaired cognition and extensive assistance of two or more people required with bed mobility, transfers, dressing, toilet use, and personal hygiene. The current care plan stated, "Focus: The resident has an ADL [activities of daily living] self care performance deficit R/T [related to] Fatigue . . . Interventions . . . BED MOBILITY: Extensive assist of 2. DRESSING: Extensive assist of 2. . . . PERSONAL HYGIENE: Resident requires assist of 2. TOILET USE: Resident requires 2 staff assist. TRANSFER: Resident requires 2 staff assist, sit to stand transfers with small harness or full body lift if being combative. . . . Focus: The resident has skin tear to top of Rt [right] hand. . . .	F 225		

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 _____	C 05/24/2017

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 225	Continued From page 22 Interventions: Keep skin clean and dry. Use lotion on dry scaly skin. Monitor location, size and treatment of Skin tear. . . ." During a family interview on 05/23/17 at 5:45 p.m., Resident #3's family member stated she observed bruises to both of the resident's wrists. She asked staff what happened and they were unsure. Observation on 05/23/17 at 6:13 p.m. showed a bruise to Resident #3's left and right wrist. The medical record failed to address Resident #3's bruises on her wrists. During an interview on 05/24/17 at 10:09 a.m., an administrative nurse (#1) confirmed staff failed to complete an investigation on Resident #3's bruises. The facility failed to report Resident #3's injury of unknown origin to the State Survey Agency within the required timeframe and submit the follow-up report within five days.	F 225		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that	F 278		7/7/17

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 _____	C 05/24/2017

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 278	Continued From page 23 the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 3.0), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDS) for 2 of 12 sampled residents (Resident #4 and #10). Failure to accurately complete Section H (Bowel and Bladder) and Section O (Special Treatments, Procedures, and Programs) does not allow each assessment to reflect the resident's current status/needs and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents.	F 278	1. Res #4 MDS with the ARD date of 5/8/2017 was modified (to capture only the accurate required look-back period) on May 23, 2017. Res. # 10 MDS was modified on 5-30-2017 with accurate coding to Sect. O per CMS RAI manual□s specifications. 2. This deficient practice has the potential to affect all residents in the facility on the MDS. 3. MDS staff will be reeducated with the	

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 _____	C 05/24/2017

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 278	Continued From page 24 Findings include: PSYCHOLOGICAL THERAPY The Long-Term Care Facility RAI User's Manual, revised October 2016 Chapter 3 page O-21 and Appendix A page 17 states, ". . . For purposes of the MDS, providers should record services for . . . psychological, when the following criteria are met: - the physician orders the therapy; - the physician's order includes a statement of frequency, duration, and scope of treatment; - the services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel; . . . - the services must be reasonable and necessary for treatment of the resident's condition. . . . Psychological Therapy; The treatment of mental and emotional disorders through the use of psychological techniques designed to encourage communication of conflicts and insight into problems, with the goal being relief of symptoms, changes in behavior leading to improved social and vocational functioning, and personality growth. . . ." - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, psychotic disorder, anxiety, and restlessness/agitation. A significant change Minimum Data Set (MDS), dated 03/21/17, and an annual MDS, dated 12/21/16, identified severely impaired cognition and 15 minutes of psychological therapy. Progress notes, dated 12/14/16 and 03/16/17,	F 278	CMS RAI manual on June29, 2017 on the Assessment Reference Dates and the meaning of the 7 day look-back period with the last day being that of the ARD date itself and Section O therapy coding by the Director of Nursing or designee. 4. QA coordinator or designee will audit on accuracy of the Assessment Reference Date and coding of Section O and section H weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters or as deemed necessary by QAPI committee . Audit results will be submitted to the QAPI for review and further recommendations.	

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 _____	C 05/24/2017

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 278	Continued From page 25 documented a visit from a psychiatrist to review medications. During an interview on 05/24/17 at 11:20 a.m., a nurse manager (#2) confirmed the miscoded psychological therapy for Resident #10. CONSTIPATION The Long-Term Care Facility RAI User's Manual, revised October 2016 Chapter 3 page H-12 and H-13 states, ". . . DEFINITION CONSTIPATION If the resident has two or fewer bowel movements during the 7-day look-back period of if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements). . . . Coding Instructions *Code 0, no: if the resident shows no signs of constipation during the 7-day look-back period. *Code 1, yes: if the resident shows signs of constipation during the 7-day look-back period. . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included constipation. The admission MDS, dated 05/08/17, identified constipation. The bowel record identified Resident #4 had six bowel movements during the seven-day look-back period. During an interview on 05/23/17 at 3:50 p.m. an administrative nurse (#4) confirmed the miscoded constipation for Resident #4.	F 278		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life	F 309		7/7/17

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 _____	C 05/24/2017

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 26 Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: TIMELY ASSESSMENTS	F 309	1. Resident #11s wound data collection assessment was completed and included	

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 _____	C 05/24/2017

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 27 1. Based on record review, review of facility policy, and staff and resident interview, the facility failed to provide the necessary care and services to ensure staff completed appropriate and timely assessments for 1 of 1 sampled resident (Resident #8) after a hospitalization. Failure to obtain and review hospital reports, including lab results, resulted in a delayed identification of a medication error. Failure to appropriately assess physical symptoms related to antibiotic use resulted in a delayed identification of an adverse antibiotic reaction. Findings include: Review of Resident #8's medical record occurred on all days of survey. Diagnoses included heart failure, urinary tract infection (UTI), hypertension, anxiety disorder, macular degeneration, and altered mental status. A quarterly Minimum Data Set (MDS), dated 04/25/17, identified intact cognition. Review of the progress notes identified the following: * 04/18/17 6:40 p.m. - "CNA [certified nursing assistant] summoned nurse into resident's room. Found resident slumped over on bed on her left side. Resident mumbling and very lethargic. Unable to tell me what is wrong . . . No response when asked if having chest pain . . . [Physician] notified and orders received to send to ER [emergency room] for evaluation." * 04/20/17 4:20 p.m. - "Resident returned with staff from [hospital] with dx [diagnoses]: altered mental status and UTI. New meds [medications] Bactrim D/S [antibiotic] 1 tab po [by mouth] BID [twice daily] for 14 tabs. . . ."	F 309	assessment of the surrounding skin on May 26, 2017. Resident #8 received appropriate antibiotic and condition was resolved on April 25, 2017. 2. All residents with wounds and hospitalized have the potential to be affected from this deficient practice 3. The nursing staff will be reeducated on complete documentation of wounds on the Wound Data Collection Sheet, including surrounding skin, appropriate assessments, treatments, hospital returns and adverse reactions to antibiotic use by the Director of Nursing or designee, on June 29, 2017 or by their next scheduled shift. 4. QA coordinator or designee will audit on appropriate assessments, treatments and complete and accurate Wound Data Collection assessments weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters or as deemed necessary by QAPI committee . Audit results will be submitted to the QAPI for review and further recommendations.	

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 _____	C 05/24/2017

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 28 * 04/23/17 1:07 p.m. - "Resident did co [complain of] dizziness this morning and had tray in room for breakfast. . . ." * 04/23/17 6:45 p.m. - "Residents family came to this nurse and said they had concerns regarding Mothers nausea which had started this am [morning]-resident states that she has nausea and dry heaves-and feels light headed and hasn't eaten well today . . . one time dose of Ondansetron [anti-nausea medication] . . . with continued monitoring. . . ." * 04/23/17 9:41 p.m. - "Resident did have a small liquid emesis during hs [bedtime] cares. . . ." * 04/24/17 4:00 a.m. Late Entry - "Res [resident] went to the clinic today for a follow-up after recent hospitalization. Family did go along and later afternoon brought to Administrator's attention a lab value of concern. DNS [Director of Nursing Services] called hospital and the lab report was faxed to the facility. Incident report initiated." * 04/24/17 10:01 a.m. - "Res.ident [sic] continues on antibiotic for UTI with no adverse side effects noted . . . does complain of dizziness, nausea, and weakness. . . ." * 04/24/17 2:44 p.m. - "Resident returned from clinic appt [appointment] . . . new orders for resident. discontinue bacterium [Bactrim] due to repeat UA [urine analysis] being negative. . . ." Resident #8's hospital admission history and physical (H&P), dated 04/18/17, stated, ". . . Quite sedated . . . Altered mental status, question etiology [cause], assess urine drug screen." The hospital discharge summary, dated 04/20/17, stated, ". . . mild urinary tract infection . . . really seemed that the patient was sedated with some sort of medication, unknown etiology . . . I did	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 _____	C 05/24/2017

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 29	F 309		

place her on Bactrim due to the possibility that it could be urinary tract infection . . . According to nursing home records and report, the patient was found unresponsive while on rounds . . . reported to ED [emergency department]. At that time though she did have her eyes open not to commands, but was very sleepy and nonverbal . . . Urine drug screen was ordered, that is still pending. I did have a long conversation with the patient on discharge about possibility of medication mixup at the nursing home as . . . roommate is on benzodiazepines. . . ."

Review of the urine toxicology report, dated 04/19/17, identified positive for "Tricyclics" (anti-depressant) and "Benzodiazepines" (anti-anxiety).

Review of a provider's note, dated 04/25/17, stated, ". . . seen today in followup of clinic visit . . . she began to be nauseated and had vomiting with poor intake and was seen yesterday at the clinic. AT THAT TIME, IT WAS NOTED THAT THE PATIENT WAS INTOLERANT TO BACTRIM, WHICH MAY BE CAUSING THE NAUSEA AND VOMITING . . . extremely fatigued . . . Will start her on Zofran ODT 4 mg [milligrams] every 8 hours p.r.n. [as needed] for 3 days. . . ."

During an interview on 05/23/17 at 8:45 a.m., Resident #8 indicated about a month ago she had been admitted to the hospital due to staff administering the wrong medications. After returning from the hospital on an antibiotic for a UTI, the resident stated she became nauseated, weak, and dizzy and had to return to the clinic where the physician diagnosed an allergy to the

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 _____	C 05/24/2017

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 30 antibiotic. During an interview on 05/23/17 at 3:50 p.m. and on 05/24/17 at 8:15 a.m., an administrative nurse (#1) verified staff failed to identify a medication error had occurred on 04/18/17 until the resident's family brought the urine toxicology results to the Administrator's attention on 04/24/17. The administrative nurse (#1) failed to thoroughly investigate the error, identify causative factors to prevent further errors, and educate all nursing staff to prevent additional errors. The administrative nurse (#1) stated nursing staff failed to identify the resident's nausea, vomiting, and weakness as a possible allergic reaction of the antibiotic until the family voiced a concern. The facility failed to obtain and review the hospital records upon the resident's nursing home re-entry to ensure appropriate assessments and treatment, and staff failed to identify a possible allergic reaction of an antibiotic in a timely manner. Wound Care Dressing 2. Based on observation, record review, review of facility policies, review of professional reference, and staff interview, the facility failed to provide the necessary care and services to ensure overall well-being of 1 of 1 sampled resident (Resident #11). Failure to assess and document the skin condition surrounding a dressing may result in the resident experiencing a worsening of the wound infection. Findings Include:	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 _____	C 05/24/2017

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 31 Review of the facility policy titled "Wound Dressing Change" occurred on 05/24/17. This policy, revised May 2016, stated, ". . . 18. Chart dressing change and wound observations on the Wound Data Collection. . . ." Review of the professional reference Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 856, states, ". . . PRACTICE GUIDELINES Assessing Before Applying Bandages or Binders . . . Inspect and palpate the area for swelling. . . . Inspect for the presence of and status of wounds . . Note the presence of drainage (amount, color, odor, viscosity). Inspect and palpate for adequacy of circulation (skin temperature, color, and sensation). Ask the client about any pain experienced . . ." Review of Resident #11's medical record occurred on 05/24/17. Diagnoses included cellulitis wound of the right ankle. The physician order stated "daily dressing changes to right lower leg with debridement at [name] clinic - keep site clean and dry. Change outer dressing only - Leave smaller dressing underneath for clinic staff to change at clinic. Resident #11's current care plan stated, ". . . Problem . . . The resident has venous/stasis ulcer to RLE [right lower extremity] noted upon admission E/B [evidenced by] need for daily dressing changes and assessment for healing . . . Interventions . . . Evaluate wound for: Size, Depth, Margins: peri-wound skin, sinuses, undermining, exudates, edema, granulation,	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 _____	C 05/24/2017

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 32 infection, necrosis, eshcar, gangrene. Document indicated. Treatment per MD [medical doctor] orders. . . ." Resident #11's Treatment Administration Record (TAR) lacked documentation of a skin assessment of the area around the telfa dressing. Observation on 05/24/17 at 8:05 a.m. showed a staff nurse (#14) removed Resident #11's outer dressing on the right ankle wound, assessed the area around the inner telfa dressing, and replaced the outer dressing. The staff nurse (#14) failed to document the skin condition surrounding the telfa dressing. During an interview on 05/24/17 at 9:50 a.m., an administrative nurse (#4) stated she expected staff nurses to assess the skin around Resident #11's telfa wound dressing and document the findings.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 314		7/7/17

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 _____	C 05/24/2017

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 314	Continued From page 33 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility procedure, and staff interview, the facility failed to provide the necessary care and services to prevent the worsening of current pressure ulcers for 1 of 2 sampled residents (Resident #3) with a current pressure ulcer. Failure to assess and monitor Resident #3's coccyx pressure ulcer as per facility policy may result in deterioration of an existing pressure ulcer. Findings include: Review of the facility procedure titled "SKIN ASSESSMENT, PRESSURE ULCER PREVENTION AND DOCUMENTATION REQUIREMENTS" occurred on 05/24/17. This procedure, revised April 2016, stated, ". . . PROCEDURE . . . 5. A systematic skin inspection will be made daily by the nursing assistant assigned to those residents at risk for skin breakdown. The nursing assistant responsible for this will report any abnormal findings or signs of skin impairment to the licensed nurse. . . . 7. If a pressure ulcer is identified . . . The registered nurse should record the type of wound and the degree of tissue damage on the Wound RN [registered nurse] Assessment . . . (i.e. [in example], for a pressure ulcer, record the stage). The licensed nurse records the location of the area, the measurements and the ulcer/wound characteristics. Document the information on the Wound Data Collection . . . 14. The pressure	F 314	1. Resident #3 wound healed on June 8, 2017 and is indicated on a wound data collection assessment 2. All residents with wounds could be affected by this deficient practice. 3. Nurses will be reeducated on completing wound data collection assessments to include measurements, accurately on June 29, 2017 or by their next schedules shift by the Director of Nursing or designee. 4. QA coordinator or designee will audit residents with pressure wounds for complete and accurate assessments, weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters or as deemed necessary by QAPI committee . Audit results will be submitted to the QAPI for review and further recommendations.	

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 _____	C 05/24/2017

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 314	Continued From page 34	F 314		

ulcer should be assessed/evaluated at least weekly and documented on the Wound RN Assessment . . . Observations of the ulcer's characteristics may be documented by a licensed nurse and should include at least the following: *Measurements - length, width, depth *Characteristics of the ulcer - including wound bed, undermining and tunneling, exudate, surrounding skin, etc. *Presence of pain *Current treatments . . ."

Review of Resident #3's medical record occurred on all days of survey. A physician order, dated 02/13/17, stated, "Vitamin A&D ointment topical to coccyx two times a day for pin sized area." The significant change Minimum Data Set (MDS), dated 03/10/17, identified one stage one pressure ulcer. The current care plan stated, "Focus: The resident H/O [history of] small area to coccyx pressure ulcer. . . . Interventions: Educate resident/family as to causes of skin breakdown . . . Provide gel cushion in chair. Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. . . ."

Observation on 05/22/17 at 4:07 p.m. showed two certified nursing assistants (CNAs) (#10 and #19) performed incontinent cares for Resident #3. Observation showed an open area smaller than pea size on Resident #3's coccyx. One CNA (#10) stated the resident received A&D ointment twice a day and has had the open area for a long time.

The progress notes identified the following: *02/06/17 at 6:22 a.m.: "CNA summoned nurse

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 _____	C 05/24/2017

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 314	Continued From page 35	F 314		

into room. Resident has small pinhole to buttocks measuring approximately 0.2cm [centimeters] in width and 0.1cm depth. Skin blanches around area. No redness noted. MD [medical doctor] faxed." The assessment lacked measurement of the length.
*02/06/17 at 8:29 a.m.: "Clinic faxed orders to avoid pressure, duoderm every 3 days, and to monitor and document every 3 days."

"Wound Data Collection" forms dated 02/13/17, 02/14/17, 02/15/17, 02/16/17, 02/17/17, 02/28/17, 03/01/17, 03/02/17, and 03/03/17 failed to identify the measurements of Resident #3's coccyx pressure ulcer.

"Skin Observation" forms dated 03/28/17, 04/18/17, and 05/02/17 failed to identify Resident #3's coccyx pressure ulcer.

A progress note dated, 03/10/17 at 9:32 p.m., stated, ". . . Applying A&D ointment to open area on coccyx. . . ."

The May 01-23, 2017 Medication Administration Record (MAR) showed staff administered Resident #3's A&D ointment to her coccyx 43 times. However, facility staff failed to assess and document on Resident #3's coccyx pressure ulcer.

During an interview on 05/22/17 at 5:10 p.m., an administrative nurse (#4) stated she thought Resident #3's coccyx pressure ulcer healed.

During an interview on 05/23/17 at 8:00 a.m., an administrative nurse (#4) stated staff failed to notify her Resident #3's coccyx opened up again.

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 _____	C 05/24/2017

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 314	Continued From page 36	F 314		

The medical record lacked evidence to show Resident #3's coccyx pressure ulcer had healed.

During an interview on 05/23/17 at 2:04 p.m., an administrative nurse (#1) stated she expects staff to complete weekly skin assessments if the resident has an area of concern.

Observation on 05/23/17 at 2:55 p.m. showed two CNAs (#10 and #11) assisted a nurse (#12), who measured Resident #3's coccyx pressure ulcer. The length measured 0.5 cm, the width measured 0.5 cm, and the depth measured 0.25 cm. One CNA (#10) stated Resident #3's area on her coccyx started as a pinpoint area and has been open since. The CNA (#10) stated when she works she documents the open area.

The April 24, 2017 through May 22, 2017 CNA "Skin Check" documentation showed an open area on Resident #3's buttock on nine days.

A "Wound Data Collection" form, dated 05/23/17 at 3:06 p.m. (106 days since the last measurement), stated, "1. Wound name . . . coccyx - pin sized - open area. . . . 3. Site location . . . Coccyx . . . 4. Length cm .5 [0.5 cm] 5. Width cm .5 [0.5 cm] 6. Depth cm .25 [0.25 cm] 7. Identification comments: pinpoint open area 2. Daily Monitoring . . . 1a. Evaluation of the ulcer if no dressing is present: no drainage, no redness around area. skin around area is intact. . . . faxed doctor to notify of open area."

The facility failed to complete an accurate initial assessment on Resident #3's coccyx pressure ulcer and failed to assess and measure the pressure ulcer weekly.

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 _____	C 05/24/2017

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 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced	F 315		7/7/17

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 _____	C 05/24/2017

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 315	Continued From page 38 by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide appropriate catheter cares for 1 of 1 sampled resident (#6) observed with a Foley catheter. Failure to provide appropriate catheter cares may result in urinary tract infections (UTIs). Findings include: Review of the facility policy titled "Catheter Care" occurred on May 23, 2017. This policy, revised November 2013, stated, ". . . 4. . . . For male resident, grasp penis and gently draw foreskin back as necessary. Cleanse around meatus toward shaft of penis with one stroke. Then cleanse for four inches downs the catheter. Replace foreskin after cleansing. (When using cotton balls or pads, discard after each use.) . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included history of urinary tract infections, retention of urine, and indwelling Foley catheter. Observation on 05/23/17 at 9:11 a.m. showed a staff nurse (#12) performed catheter cares. The staff nurse (#12) placed a basin of water containing a skin cleansing solution on the bedside table, soaked a washcloth in the basin, wiped the resident's meatus down the shaft of the penis, and placed the soiled washcloth back into the basin. The staff nurse (#12) then opened a 4x4 dressing gauze, soaked the gauze into the same cleansing solution containing the soiled washcloth, and wiped around the resident's foreskin, and placed the soiled gauze back into the basin. Next the staff nurse (#12) opened a	F 315	1. Resident #6 will have catheter care and catheter drainage bag emptying per GSS procedure. 2. Any resident with a Foley Catheter has the potential to be affected by this deficient practice. (At present this is the only resident in the facility with a catheter.) 3. The Nursing Staff will be reeducated on the Catheter Care and Catheter Drainage Bag Emptying with return demonstration by the Staff Development Coordinator or designee, on June 29, 2017, or before their next scheduled shift. 4. QA coordinator or designee will do observation audits will be done, weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters or as deemed necessary by QAPI committee . Audit results will be submitted to the QAPI for review and further recommendations.	

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 _____	C 05/24/2017

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 315	Continued From page 39 second 4x4 dressing gauze, soaked the gauze again in the same basin, and wiped down the catheter tubing. The staff nurse (#12) then emptied the Foley catheter bag into a urinal and replaced the port. The staff nurse (#12) failed to wipe the port with an alcohol swab. During an interview on 05/24/17 at 10:00 a.m., an administrative nurse (#1) stated she expected staff to wipe the urinal bag port with alcohol after emptying the urine contents. Also, she stated, during foley cares she expected staff to discard gauze wipes and not place soiled washcloths back into the cleansing solution.	F 315		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain	F 323		7/7/17

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 _____	C 05/24/2017

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 323	Continued From page 40 informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: TRANSFERS 1. Based on observation, record review, and staff interview, the facility failed to ensure each resident received adequate supervision and the necessary assistive devices to prevent accidents for 2 of 6 sampled residents (Resident #3 and #5) observed transferred with a gait belt or a full body mechanical lift. Failure to assess and utilize appropriate methods of transfer increased the risk of falls and injury for these residents. Findings include: - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia with behaviors, and psychosis. A significant change Minimum Data Set (MDS), dated 03/10/17, identified severely impaired cognition, extensive assistance of two or more people required with bed mobility, transfers, dressing, toilet use, and personal hygiene. The current care plan stated, "Focus: The resident has an ADL [activities of daily living] self care performance deficit R/T [related to] Fatigue . . . Interventions . . . TRANSFER: Resident requires 2 staff assist, sit to stand transfers with small harness or full body lift if being combative. . . ." Review of the "Mobilization Support Data Collection Tool" dated 03/05/17 stated, ". . .	F 323	1. Resident #3 Mobilization Support Data Collection Tool was completed on May 24, 2017 and she is being transferred now with Full Body lift and was also evaluated for the ability to safely handle hot liquids and now has her hot liquids in a covered sip container on and the care plan was updated on May 24, 2017. Resident #5 is being transferred with the use of a gait belt and a front wheel walker. 2. All residents have the potential to be affected by this deficient practice. 3. Nursing staff will be reeducated on updating care plans with safety interventions, hot beverage safety, and following the plan of care and the procedure of transfers and use of the Gait Belt by the Director of Nursing or designee on June 29, 2017 or by their next scheduled shift. 4. QA coordinator or designee will audit Care Plans to ensure updated and to ensure accuracy and that the interventions are being followed through with, by observations for compliance on random shifts. This will be completed weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters or as deemed	

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 _____	C 05/24/2017

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 323	Continued From page 41 Mobility Task #6 - Transfer Between Surfaces:Leg Strength 1. From a seated position, can the resident demonstrate leg strength in at least one leg by raising leg as if marching or kicking when moderate resistance/pressure is applied? a. Yes . . . 2. In a seated position, can the resident place hands on either side of the body and push off or rise off the surface 1 to 2 inches and sit down again? . . . b. No, use sit-to-stand . . ." The facility failed to determine when a full body mechanical lift would be appropriate for Resident #3. Observations throughout the survey showed the following: *05/23/17 at 1:11 p.m.: Two certified nursing assistants (CNAs) (#8 and #9) transferred Resident #3 from the wheelchair to the toilet and then to the recliner with a sit-to-stand mechanical lift. During an interview on 05/23/17 at 2:40 p.m., a CNA (#10) stated staff usually transfer Resident #3 with a sit-to-stand mechanical lift. If Resident #3 is combative and not as alert, staff would use a full body mechanical lift. *05/23/17 at 2:55 p.m.: Two CNAs (#10 and #11) transferred Resident #3 from the recliner to the bed with a full body mechanical lift after getting permission from a nurse (#12). Observation showed Resident #3 cooperative before, during, and after the transfer, and not combative. *05/23/17 at 4:13 p.m.: Two CNAs (#10 and #11) transferred Resident #3 from the bed to her wheelchair with a full body mechanical lift after getting permission from a nurse (#13). One CNA (#10) stated she likes to use the full body lift for safety reasons because Resident #3's knees buckle sometimes. Observation showed Resident	F 323	necessary by QAPI committee. Audit results will be submitted to the QAPI for review and further recommendations.	

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 _____	C 05/24/2017

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 323	Continued From page 42 #3 cooperative before, during, and after the transfer, and not combative. The medical record lacked evidence facility staff completed an assessment to determine the safety of a full body mechanical lift and the facility staff failed to follow the care plan regarding when to use the full body mechanical lift. During an interview on 05/23/17 at 4:26 p.m., an administrative nurse (#1) confirmed staff failed to assess the safety of Resident #3 transfers with a full body mechanical lift. - Review of Resident # 5's medical record occurred on all days of survey. Diagnoses included abnormal gait, osteoarthritis, pain of right knee, and history of pathological fracture. The current care plan stated ". . . Problem . . . The resident has limited physical mobility R/T [relate to] Gait disturbance E/B [evidenced by] Weakness . . . Interventions . . . Mobility: Resident requires 1 staff assistance and front wheeled walker/gait belt for transfers. . . ." Observation on 05/23/17 at 9:39 a.m. showed a CNA (#7) assisted Resident #5 from the wheelchair to her bed. Resident #5 pulled herself up to a standing position grabbing onto the bed rail, and pivoted into bed. The CNA (#7) failed to utilize a gait belt and front wheeled walker. Observation on 05/23/17 at 11:38 a.m. showed a staff nurse (#14) assisted Resident #5 from the bed to her wheelchair. Resident #5 sat up on the edge of the bed, and pivoted herself into her wheelchair. The staff nurse (#14) failed to utilize a gait belt and front wheel walker.	F 323		

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 _____	C 05/24/2017

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 323	Continued From page 43 Observation on 05/25/17 at 3:57 p.m. showed a CNA (#17) assisted Resident #5 from the bathroom toilet to her wheelchair. The resident pulled herself up to a standing position and pivoted herself into her wheelchair. The CNA (#17) failed to utilize a gait belt. During an interview on 05/24/17 at 10:00 a.m., an administrative nurse (#1) stated she expected staff to follow the care plan utilizing a gait belt and a front wheel walker when transferring Resident #5. SAFE HANDLING OF HOT LIQUIDS 2. Based on record review and staff interview, the facility failed to provide adequate supervision to attain the highest degree of safety possible while consuming hot liquids for 1 of 1 sampled resident (Resident #3) with a coffee spill. Failure to assess Resident #3 after a coffee spill for safety and possible needed assistive devices placed the resident at risk of injury. Findings include: Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia with behaviors, and psychosis. A significant change MDS, dated 03/10/17, identified severely impaired cognition and extensive assistance of one person required with eating. The current care plan stated, "Focus: The resident has an ADL self care performance deficit R/T Fatigue . . . Interventions . . . EATING: STRENGTH: Resident is able to feed self independently assist prn [as needed], encourage	F 323		

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 _____	C 05/24/2017

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 323	Continued From page 44 food and fluid intake, moved to assist room 10/22/2016. . . ." A progress note dated 04/19/17 at 9:25 a.m. stated, "Resident spilled hot coffee on her lap. Staff took her to her room and applied cold compress. This writer examined her legs and arm (areas coffee was spilled on) Slight redness noted. Resident denies any complaints of pain. Will continue to monitor." Record review lacked an investigation and intervention implementation. During an interview on 05/23/17 at 5:04 p.m., the dietary manager (#16) confirmed she was not aware of Resident #3's coffee spill. A progress note dated 05/23/17 at 6:07 p.m. (34 days after Resident #3's coffee spill) stated, "Trialing a covered cup for coffee r/t history of spilling coffee." During an interview on 05/24/17 at 10:09 a.m., an administrative nurse (#1) stated she expected staff to complete an incident report on Resident #3's coffee spill. The facility failed to assess Resident #3's ability to safely handle hot liquids and failed to implement interventions and update the care plan to further prevent a hot liquid spill and possible injury.	F 323		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:	F 328		7/7/17

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 _____	C 05/24/2017

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 328	Continued From page 45 (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the	F 328		

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 _____	C 05/24/2017

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 328	Continued From page 46 comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to provide the necessary care and services for 3 of 5 sampled residents (Resident #2, #3, and #10) who required the use of oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications and/or hospitalization related to inadequate oxygen saturation levels. Findings include: Review of the facility policy titled "Oxygen Administration with Nasal Cannula, Face Mask or Face Tent" occurred on 05/24/17. This policy, revised July 2016, stated, "Purpose: To administer various levels of oxygen concentration and/or humidity in a safe manner . . . Procedure: 1. Verify physician order. . . . 10. Turn gauge to start flow rate at prescribed liters per minute (per physician's orders) . . . 11. Place cannula, mask or tent on resident . . ." - Review of Resident #2's medical record occurred on all days of survey. A physician order,	F 328	1. Resident #2, #3 and #10 have been receiving Oxygen as ordered. 2. All Residents requiring oxygen have the potential to be affected by tis deficient practice. 3. Nursing staff will be reeducated with the procedure oxygen administration on June 29, 2017 by the Staff Development Coordinator or designee. 4. QA coordinator or designee will audit on Oxygen administration per physician weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters or as deemed necessary by QAPI committee . Audit results will be submitted to the QAPI for review and further recommendations.	

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 _____	C 05/24/2017

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 328	Continued From page 47	F 328		

dated 02/20/17, stated, "O2 [oxygen] at 2 L/NC [liters per nasal cannula] to keep O2 sats [saturation] above 92% [percent]." The current care plan stated, "Focus: The resident has Congestive Heart Failure E/B [evidenced by] need to asses [sic] for any acute respiratory/cardiac complications. . . . Interventions: . . . Oxygen therapy per MD [medical doctor] orders. Date initiated: 03/20/2015 . . ."

Resident #2's record from May 1-24, 2017 showed her O2 sats were between 92-100% on 2 liters per minute [LPM].

On 05/22/17 at 5:30 p.m., observation showed Resident #2 in the dining room in her wheelchair with an oxygen cannula in her nose. The oxygen tank on the back of the wheelchair was not turned on, with the setting at zero. A licensed nurse (#3), when asked what liter flow the oxygen was to be set at, stated, "It is supposed to be on 2 [LPM], and it is not even on. That is a goof on our part." The nurse then turned the oxygen on to 2 LPM, and stated Resident #2 used oxygen continuously.

On 05/23/17 at 9:36 a.m., observation showed Resident #2 in her room with oxygen on at 2 LPM. Two certified nurse aides (CNAs) (#5 and #6) removed Resident #2's oxygen and transferred her using a full body lift from the wheelchair to the bed to remove her clothes for a bath. The CNAs then transferred the resident to a shower chair and took her to the tub room. At 10:22 a.m., a CNA (#6) returned the resident to her room and transferred her with the lift and the assistance of a second CNA (#7) to the bed.

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 _____	C 05/24/2017

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 328	Continued From page 48	F 328		

After the CNAs dressed and transferred Resident #2 to the wheelchair, another CNA (#5) put her oxygen on and stated, "I have to get another tank as this one [oxygen tank] is out." At 10:40 a.m., the CNA (#5) wheeled the resident to the oxygen storage area, replaced the oxygen tank on the wheelchair, and turned the oxygen on at 2 LPM. Resident #2 was without supplemental oxygen for 64 minutes.

During an interview on 05/24/17 at 10:15 a.m., a nurse manager (#2) stated Resident #2's oxygen order meant the resident only needed oxygen if the O2 sat was less than 92%, and only needed to keep the oxygen on all the time if the order said continuous. This conflicts with the statement from the licensed nurse (#3) which stated Resident #2 used oxygen continuously. The nurse stated the record lacked documentation of an O2 sat before staff removed Resident #2's oxygen for the bath on 05/23/17, and staff should have checked the O2 sat after removing the oxygen. The nurse stated the record for May showed staff documented Resident #2's O2 sats while on the oxygen at 2 LPM, and she did not know what the resident's O2 sats were without the oxygen in use.

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included hypoxemia, shortness of breath, heart failure, and anxiety. The current care plan stated "Focus: The resident has potential for altered cardiovascular status R/T [related to] HTN [hypertension] [high blood pressure] E/B [evidenced by] L/E [lower extremity] edema. . . . Interventions: Oxygen therapy as ordered. . . ." Physician orders included continuous oxygen at

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 _____	C 05/24/2017

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 328	Continued From page 49 two to four liters per nasal cannula. A hospital discharge summary dated 03/05/17 stated, "ADMITTING DIAGNOSIS: Shortness of breath with hypoxemia. FINAL DIAGNOSES: Shortness breath with hypoxic episode without oxygen, resolved. BRIEF HISTORY AND ESSENTIAL PHYSICAL FINDINGS . . . The nursing staff had checked her oxygen level and found that her oxygen saturation in 60s. The patient was brought to the emergency room and found that the patient did not have the oxygen tank on, so the patient was receiving no oxygen through the nasal cannula. Once oxygen was started on the patient, her oxygen saturations returned to the 90%. . . ." Failure to administer Resident #3's oxygen as prescribed resulted in a hypoxic episode and an emergency room visit. - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, psychotic disorder, anxiety, and restlessness/agitation. Random observations throughout survey showed Resident #10 on oxygen at 2 liters per nasal cannula. A physician's order, dated 04/01/17 stated, "02 at 2-3 liter to keep 02 sats > [greater than] 90% prn as needed for Low 02 sats related to HYPOXEMIA." Review of vital signs for May 01-23, 2017 showed staff documented "Oxygen via nasal cannula" on 10 days with sats between 93% and 99%. Review of the electronic medication	F 328		

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 _____	C 05/24/2017

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 328	Continued From page 50 administration record for May 01-23, 2017 showed staff failed to document the PRN oxygen usage. During an interview on 05/24/17 at 11:00 a.m., a nurse manager (#2) stated a physician had ordered oxygen PRN on April 1, 2017 due to an upper respiratory infection, but Resident #10 had not used oxygen during the month of May. During an interview on 05/24/17 at 11:09 a.m., a CNA (#7) stated she was unaware of Resident #10's change in oxygen needs, and had placed the resident's oxygen at 2L/NC yesterday and today during morning cares. Failure to administer oxygen per physician's order may result in the use of unnecessary oxygen.	F 328		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or	F 329		7/7/17

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 _____	C 05/24/2017

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 329	Continued From page 51 discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to ensure each resident's drug regimen is free from unnecessary medications for 3 of 3 sampled residents (Resident #1, #3, and #10) receiving antipsychotic medications. Failure to ensure adequate monitoring and complete the Abnormal Involuntary Movement Scale (AIMS) as per facility policy limited the facility's ability to recognize and evaluate an unanticipated decline or newly emerging or worsening symptom and modify the drug regimen as appropriate. Findings include:	F 329	1. Residents #1 on 6/9/2017, #3 on 5/30/17, and #10 on 5/30/17 had an AIMs test completed by RN. 2. All residents on medications requiring AIMS have the potential to be affected by this deficient practice. 3. Licensed Staff will be educated on the Policy and Procedure Psychotropic Medications A list of complied of all residents on medications requiring and AIMs screening. AIMs have been conducted for all those due according to our GSS Policy by the Director of Nursing	

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 _____	C 05/24/2017

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 329	Continued From page 52 Review of the facility policy titled "Psychotropic Medications" occurred on 05/24/17. This policy, revised November 2016, stated, ". . . Purpose: . . . To eliminate unnecessary psychotropic medications . . . Policy: . . . 5. If the physician prescribes an antipsychotic for the resident, a registered nurse must complete the Initial Antipsychotic Medication Assessment and the Abnormal Involuntary Movement Scale. . . . 8. If a resident is admitted on psychotropic medications or returns from hospitalization on new psychotropic medications, the following must be completed: . . . c. If the medication is an antipsychotic, a registered nurse must complete the Abnormal Involuntary Movement Scale. . . . 9. Throughout the administration of the psychotropic medications, the following must be completed: . . . c. If the resident is on an antipsychotic, a registered nurse must complete the Abnormal Involuntary Movement Scale every six months. . . ." - Review of Resident #1's medical record occurred on all days of survey. A physician order, dated 05/11/17, stated, "Abilify Tablet (aripiprazole) [an antipsychotic] Give 2 mg [milligrams] by mouth one time a day related to Major Depressive Disorder, Recurrent, Mild." This was an increase from the initial order on 04/12/17 of 1 mg daily. Resident #1's record lacked evidence staff completed the AIMS when the physician prescribed Abilify on 04/12/17. During an interview on 05/24/17 at 11:17 a.m., a nurse manager (#2) stated facility staff completed an AIMS for Resident #2 on admission to the	F 329	or designee. 4. QA coordinator or designee will audit completion of AIMs Tests accurately weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters or as deemed necessary by QAPI committee. Audit results will be submitted to the QAPI for review and further recommendations.	

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 _____	C 05/24/2017

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 329	Continued From page 53	F 329		

facility in January 2017, not when the physician first prescribed the antipsychotic.

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included psychosis. The physician first prescribed Risperdal on 10/12/16. Since then the dose has been increased. A physician order, dated 05/11/17, stated, "Risperdal Tablet (Risperidone) Give 0.25 mg by mouth two times a day for Paranoid related to UNSPECIFIED PSYCHOSIS . . ."

The record identified an AIMS completed on 04/19/16 (Resident #3's admission date), not when the physician first prescribed the antipsychotic.

During an interview on 05/24/17 at 10:09 a.m., an administrative nurse (#1) confirmed facility staff failed to complete an AIMS when the physician first prescribed Risperdal (10/12/16) and six months later (04/12/16).

- Review of Resident #10's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, psychotic disorder, anxiety, and restlessness/agitation. Review of the medication orders showed Seroquel (initiated on 06/26/16) 400 mg daily and 100 mg twice daily. Current orders are 400 mg daily and 200 mg twice daily.

The record identified an AIMS completed on 07/19/16, not when the physician first prescribed the antipsychotic.

During an interview on 05/24/17 at 1:00 p.m., a

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 _____	C 05/24/2017

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 329	Continued From page 54 nurse manager stated staff failed to complete an AIMS six months later (01/19/17).	F 329		
F 333 SS=G	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure 2 of 2 sampled residents (Resident #5 and #8) remained free of significant medication errors. Failure to ensure Resident #8 received the correct medications resulted in hospitalization for two days. Failure to administer a fentanyl (pain medication) patch on the correct day and administer a dose of Vancomyocin (antibiotic) intravenous medication to Resident #5 may result in a negative outcome. Findings include: Review of the facility policy titled "Medication Errors" occurred on 05/24/17. This policy, revised May 2016, stated, ". . . ensure . . . that residents are free of significant medication errors . . . Medication errors consist of the following: * Wrong Medication * Wrong Time * Wrong Resident Given the Medication/Unauthorized Medication (drug administered without a physician's order) * Omission of Medication Ordered. . . ."	F 333	1. Resident #5 and Resident #8 have received medications as ordered. Incident/Medication error reports have been completed. 2. All residents receiving medications have the potential to be affected by this deficient practice. 3. Nurses and Medication Aids will be educated on the procedures of Medication Administration and Medication Error procedures and reports by a Registered Nurse Educator or designee, for our community on June 29, 2017 or by their next scheduled shift. 4. QA coordinator or designee will audit on medication Errors and administration weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters or as deemed necessary by QAPI committee . Audit results will be submitted to the QAPI for review and further recommendations.	7/7/17

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 _____	C 05/24/2017

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 333	Continued From page 55	F 333		

Review of the facility policy titled "MEDICATION ADMINISTRATION, INCLUDING SCHEDULING AND MEDICATION AIDES" occurred on 05/24/17. This policy, revised May 2016, stated, ". . . Medication Errors . . . An incident report will be completed for all medication errors. . . ."

- Review of Resident #8's medical record occurred on all days of survey. Diagnoses included heart failure, urinary tract infection (UTI), hypertension, anxiety disorder, macular degeneration, and altered mental status. A quarterly Minimum Data Set (MDS), dated 04/25/17, identified intact cognition.

Review of the progress notes identified the following:
* 04/18/17 6:40 p.m. - "CNA [certified nursing assistant] summoned nurse into resident's room. Found resident slumped over on bed on her left side. Resident mumbling and very lethargic. Unable to tell me what is wrong . . . No response when asked if having chest pain . . . [Physician] notified and orders received to send to ER [emergency room] for evaluation."
* 04/20/17 4:20 p.m. - "Resident returned with staff from [hospital] with dx [diagnoses]: altered mental status and UTI. . . ."
* 04/24/17 4:00 a.m. Late Entry - "Res [resident] went to the clinic today for a follow-up after recent hospitalization. Family did go along and later afternoon brought to Administrator's attention a lab value of concern. DNS [Director of Nursing Services] called hospital and the lab report was faxed to the facility. Incident report initiated."

Resident #8's hospital admission history and

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 _____	C 05/24/2017

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 333	Continued From page 56	F 333		

physical (H&P), dated 04/18/17, stated, ". . . Quite sedated . . . Altered mental status, question etiology [cause], assess urine drug screen." The hospital discharge summary, dated 04/20/17, stated, ". . . really seemed that the patient was sedated with some sort of medication, unknown etiology . . . According to nursing home records and report, the patient was found unresponsive while on rounds . . . reported to ED [emergency department]. At that time though she did have her eyes open not to commands, but was very sleepy and nonverbal . . . Urine drug screen was ordered, that is still pending. I did have a long conversation with the patient on discharge about possibility of medication mixup at the nursing home as . . . roommate is on benzodiazepines. . . ."

Review of the hospital's urine toxicology report, dated 04/19/17, identified Resident #8 positive for "Tricyclics" (anti-depressant) and "Benzodiazepines" (anti-anxiety).

Review of Resident #8's April 2017 electronic medication administration record (eMAR) showed no anti-depressant or anti-anxiety medications ordered or administered.

Review of Resident #10's (Roommate of Resident #8) April 2017 eMAR showed one anti-anxiety medication ordered and administered, but no anti-depressant ordered.

During an interview on 05/23/17 at 8:45 a.m., Resident #8 indicated about a month ago she had been admitted to the hospital due to staff administering the wrong medications.

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 _____	C 05/24/2017

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 333	Continued From page 57 During an interview on 05/23/17 at 3:50 p.m. and on 05/24/17 at 8:15 a.m., an administrative nurse (#1) stated the following: * Resident #8's medication error occurred on 04/18/17 * The toxicology report showed Resident #8 received medications not ordered by a physician * Facility staff were unaware of the medication error until 04/24/17 after the resident's family brought the urine toxicology results to the Administrator's attention (Six days after the medication error occurred) * Facility staff failed to review the hospital's admission H&P or discharge summary when the resident returned on 04/20/17 or request the urine toxicology screen * Facility staff failed to investigate to determine whose medication or what medication(s) Resident #8 received * Facility staff completed only one staff interview (certified nursing assistant/certified medication aide (CNA/CMA) on duty during the medication error) * The facility failed to communicate and educate all nurses regarding the medication error The facility failed to thoroughly investigate a medication error requiring Resident #8's hospitalization for 2 days, to identify causative factors including whose medications Resident #8 received to prevent further errors, and educate all nursing staff to prevent additional errors. - Review of Resident #5's medical record occurred on all days of survey. Medications included Fentanyl patch 25 micrograms (MCG) every seventy-two hours and Vancoymycin 1 gram intravenously every other day	F 333		

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 _____	C 05/24/2017

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 333	Continued From page 58 (administered by clinic staff). Review of Resident #5's progress notes, dated 02/11/17 at 4:50 p.m., stated, "Medication Error: fentanyl patch scheduled to change today and was changed in error yesterday. resident showed no signs or symptoms of adverse reaction. . . ." Review of the investigation report dated 02/11/17 at 4:44 p.m., stated, ". . . Nurse went to sign out res [resident] fentanyl patch in narc [narcotic] book when she noted a new one had been applied just the day prior. Patch is to be [changed daily every seventy-two hours] . . ." Review of Resident #5's electronic Medication Administration Record (eMAR) for the month of December showed Vancomycin administered every other day, December 08-20, 2017. A faxed note to the physician stated, "Resident was to receive IV [intravenous] Vancomycin for [urinary tract infection] but did not receive any vancomycin for 12/18/2016." The eMAR showed the medication as administered. The facility failed to complete an incident report. During an interview on the afternoon of 05/23/17, the administrative nurse (#1) stated the staff failed to complete an incident report for the missed dose of Vancomycin.	F 333		
F 431 SS=F	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 431		7/7/17

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 _____	C 05/24/2017

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 59 law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (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. (2) The facility must provide separately locked, permanently affixed compartments for storage of	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 _____	C 05/24/2017

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 60 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, the facility failed to ensure secure storage of medications for 4 of 4 medication carts (west-south cart, west-north cart, east-south cart, and east-north cart). Failure to ensure the locking mechanism on the medication carts functioned appropriately exposed the medications to unauthorized access, increased the risk of theft of medications from the carts, and the possibility of inappropriate ingestion of an unprescribed medication by a resident. Findings include: Review of the facility policy titled "Acquisition, Receiving, Dispensing and Storage of Medications" occurred on 05/23/17. This policy, revised September 2016, stated, ". . . Procedure: . . . 4. Medications will be stored in a locked medication cart, drawer or cupboard. . . ." - On 05/22/17 at 4:52 p.m., observation of medication pass showed a licensed nurse (#3) obtained medications for a resident from the west-north medication cart, then turned the handle that locks the cart. The second drawer of the cart failed to stay completely closed. Upon attempting to open the other drawers, observation showed none of the drawers were	F 431	1. Two of the four medication carts fully locked prior to the surveyor□s exit. Immediate education was provided to license nursing staff on the steps to take to ensure medications remain secure. Parts were immediately ordered and all carts were locking and secure by June 1, 2017. 2. All residents who medications were in the carts were affected. Individual counselling for licensed staff not remembering to keep cart secure. Licensed 3. Staff and Medication Techs will be educated with the GSS Procedure Acquisition, Receiving, Dispensing and Storage of Medication on June 29, 2017, by Staff Development Coordinator or designee. 4. QA coordinator or designee will audit on medication Cart audit to ensure security will be weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters or as deemed necessary by QAPI committee . Audit results will be submitted to the QAPI for review and further recommendations.	

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 _____	C 05/24/2017

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 61 locked. The nurse (#3) attempted to lock the cart several more times without success, and stated, "We've had these carts so long." The nurse verified the medications were not secure in the cart. On 05/22/17, between 5:00 p.m. and 5:15 p.m., the licensed nurse (#3) checked the other three medication carts, west-south, east-north, and east-south, and opened the drawers without keying in the code that unlocks the carts. Observation showed none of the locks functioned on the carts. - Observation on 05/23/17 at 4:03 p.m. showed an unattended unlocked medication cart in the East main hallway with several residents walking past the medication cart to the dining room.	F 431		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (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 (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures	F 441		7/7/17

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 _____	C 05/24/2017

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 441	Continued From page 62 for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 441		

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 _____	C 05/24/2017

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 441	Continued From page 63 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: WHIRLPOOL CLEANING 1. Based on observation, review of manufacturer's guidelines, and staff interview, the facility failed to follow manufacturer's recommendations for 2 of 2 resident whirlpool bathtubs (west unit and east unit) used. Failure to follow manufacturer's recommendations when disinfecting the whirlpool bathtub between residents has the potential to spread infection within the facility. Findings include: Review of the "PENNER PATIENT CARE CASCADE AQUA-AIRE TUB OPERATION" manufacturer recommendations occurred on 05/24/17. The directions for use stated, ". . . System Cleaning (After Every Bath) Clean and disinfect the tub every morning and after every bath with Penner Cleaner/Disinfectant as follows . . . 6. With the solution that remains in the foot well of the tub, use the long-handled brush . . . to thoroughly scrub all interior surfaces of the tub, the Transfer System if used, and submerge the shower sprayer in the solution. Also scrub around door seal area and temperature probe area. Let disinfectant stay on surface for 10 minutes. . . ."	F 441	1. Instructions for disinfecting the tub were verbally given to bathing staff during survey by DNS and posted on tub room cabinets on each side after review of disinfectant directions and our tubs directions for cleaning. The Nurse was counselled related to infection control during medication pass as to hand hygiene. The Nurse was counselled related to infection control during wound dressing changes. 2. All residents receiving medications, wound care and baths could be affected by this deficient practice. 3. Nursing staff will be reeducated on hand hygiene, disinfection of the tub between resident bathing and the nurses on Wound Care and Medication Pass by the Infection Preventionist/DNS or designee on June 29, 2017 or prior to their next scheduled shift. 4. QA coordinator or designee will audit by monitoring for infection control of Nursing staff weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters or as	

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 _____	C 05/24/2017

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 441	Continued From page 64 - Observation on 05/23/17 at 10:36 a.m. showed a bath aide (#18) in the east whirlpool tub room. The bath aide (#18) explained she rinses off the disinfectant solution after five minutes. - Observation on 05/23/17 at 11:35 a.m. showed a bath aide (#6) in the west whirlpool tub room. The bath aide (#6) explained she uses a brush to scrub the entire bathtub between every other bath given. Failure to leave the disinfectant solution on the tub surfaces for 10 minutes and to scrub the bathtub between each resident may result in spread of infection. WOUND DRESSINGS 2. Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed appropriate infection control practices for 1 of 2 sampled residents (Resident #11) observed during wound dressing changes. Failure to follow infection control practices with wound dressing changes has the potential to cause or spread infection to the wound site. Findings include: Review of the facility policy titled "Wound Dressing Change" occurred on 05/24/17. This policy, revised May 2016, stated, ". . . 4. Put on gloves. . . . 7. Remove soiled dressing and discard in plastic bag, avoiding contact and thus contamination of other surfaces. Remove gloves and discard in same plastic bag. Perform hand hygiene. 8. Create field with equipment/dressing	F 441	deemed necessary by QAPI committee . Audit results will be submitted to the QAPI for review and further recommendations.	

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 _____	C 05/24/2017

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 441	Continued From page 65	F 441		

wrappers. . . . 9. Open all supplies and pour solutions if ordered. 10. Put on gloves. . . . 18. Chart dressing change and wound observations on the Wound Data Collection. . . ."

Review of Resident #11's medical record occurred on 05/24/17. Diagnoses included cellulitis wound of the right ankle. The physician order stated "daily dressing changes to right lower leg with debridement at [name] clinic - keep site clean and dry. Change outer dressing only - Leave smaller dressing underneath for clinic staff to change at clinic."

Resident #11's current care plan stated, ". . . Problem . . . The resident has venous/stasis ulcer to RLE [right lower extremity] noted upon admission E/B [evidenced by] need for daily dressing changes and assessment for healing . . . Interventions . . . Evaluate wound for: Size, Depth, Margins: peri-wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eshcar, gangrene. Document indicated. Treatment per MD [medical doctor] orders. . . ."

Observation on 05/24/17 at 8:05 a.m. showed Resident #11 seated in her recliner. A staff nurse (#14) removed Resident #11's outer dressing on the right ankle wound, removed the telfa dressing with her ungloved hands, assessed the area around the inner telfa dressing, and replaced the outer telfa dressing. Without washing her hands the nurse left the resident's room, returned, and wrapped the site with gauze wrap. The nurse dropped the ace bandage on the floor, picked up the ace bandage, and wrapped the resident's right ankle. The staff nurse (#14) failed to utilize

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 _____	C 05/24/2017

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 441	Continued From page 66	F 441		

gloves and proper hand hygiene during the wound dressing change.

During an interview on 05/24/17 at 10:00 a.m., an administrative nurse (#1) stated she expected staff to utilize gloves, wash their hands between dirty and clean dressing changes, and not use potentially contaminated dressings.

MEDICATION PASS

3. Based on observation and professional reference, the facility failed to ensure staff followed appropriate infection control practices for 1 of 6 residents (Resident #6) observed during medication pass. The facility staff failed to follow infection control practices when handling medications contained in a capsule form. Failure to follow established infection control practices may result in the spread of infection within the facility.

Findings include:

Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice." 10th ed., Pearson Education Inc., New Jersey, page 776, stated,"Administering Oral Medications . . . transfer the medication to the disposable cup without touching the tablets. . . ."

Observation on 05/22/17 at 4:27 p.m. showed a staff nurse (#3) prepared Resident #6's medications. The nurse (#3) opened up a Ziprosidine (antipsychotic medication) capsule, which contained a powder form of medication, to put into the medicine cup. As she opened the

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 _____	C 05/24/2017

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 441	Continued From page 67 capsule, some of the powder contained in the capsule spilled onto the laptop keyboards. The nurse (#3) used her ungloved hand to pick up the powder and placed it in the medicine cup. The staff nurse (#3) failed to follow infection control practices when handling medication.	F 441		