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 _____	06/23/2016

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, started on 06/20/16 and completed on 06/23/16, the sample included 3 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 6 additional residents to verify specific concerns during the survey.	F 000		
F 223 SS=E	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and resident and staff interview, the facility failed to ensure residents remained free from verbal and mental abuse for 3 of 11 sampled residents (Resident #1, #3, and #10) and 1 supplemental resident (Resident #21) who experienced or vocalized abuse from Resident #9. Failure to address Resident #9's behaviors does not ensure the safety of all residents in the facility and resulted in Resident #1 experiencing psychosocial harm. Findings include: Review of the facility policy titled "ABUSE AND NEGLECT" occurred on 06/23/16. This policy,	F 223	1. Residents #3, #10 and #1 have all spoken with the ombudsmen, but the facility is not allowed to see the report. We were made to understand from the ombudsmen that Resident #1 continues to have a problem with Resident #9, but not Resident #3 or Resident #10. LSW will meet weekly with Resident #1 to allow open communication about allegations toward Resident #9. LSW will also plan interventions as needed, and educate Resident #9 on the plan if needed. 2. This tag has the potential to affect all residents.	7/28/16

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

Electronically Signed | 07/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 223	Continued From page 1 revised September 2013, stated, ". . . POLICY The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, center staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. . . ." Review of the facility procedure titled "ABUSE AND NEGLECT" occurred on 06/23/16. This procedure, revised August 2015, stated, ". . . PROCEDURE . . . 2. The charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether an emergency treatment or action is required and complete an initial investigation. . . . The charge nurse also will ensure that any potential for further abuse is eliminated by taking one of the following actions . . . b. If it is an allegation of resident to resident abuse, the residents will be separated immediately and both ensured a safe environment. . . ." Review of the facility policy titled "ABUSE DEFINITIONS" occurred on 06/23/16. This policy, dated September 2012, stated, ". . . DEFINITIONS ABUSE: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish or deprivation of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. VERBAL ABUSE: Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance,	F 223	3. A) Ombudsmen reported the following suggestion to Social Worker: Resident #9 could present agriculture or weather report as an activity, and that Resident #9 feels a need to retaliate and/or becomes defensive when he feels someone has wronged him. LSW approached resident with offer for these things and resident agreed to report the amount of rain in the gauge after a rain and would be interested in playing checkers with a young volunteer. GSS-Oakes is attempting to find alternative placement for Resident #9 that may be better suited to his needs. Resident #9 is aware of this and behaviors stunted at this time. B) Staff educated on 7-20-2016 with the Policy and Procedure Abuse and Neglect to enable them to identify potential abusive behavior and the importance of reporting any abuse to the charge nurse. The LSW or her designee will meet weekly (or sooner if needed) with the residents who have c/o being abused and try to resolve the issue with interventions appropriate to each situation. 4. An audit will be conducted to ensure that the LSW or designee is meeting with Resident #1 and any other residents who have c/o being abused and if any new interventions are being put into place. Audit will be done weekly x4, monthly x2, quarterly x3 and then as deemed necessary by the QA committee. Audit will be completed by the QA coordinator or designee and reviewed by the QA committee.	

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GOOD SAMARITAN SOCIETY - OAKES	213 N 9TH ST OAKES, ND 58474

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F 223	Continued From page 2	F 223		

regardless of their age, ability to comprehend or disability. . . . MENTAL ABUSE: Includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. . . ."

Review of the facility policy titled "RESIDENT RESPONSIBILITIES" occurred on 06/23/16. This policy, revised March 2012, stated, ". . . The following are some guidelines that we ask you to follow: Respect the rights and property of others. Treat other residents and their guests with courtesy. . . . Be kind and considerate of roommates and other residents. . . ."

Review of the facility policy titled "BEHAVIOR MANAGEMENT COMMITTEE" occurred on 06/23/16. This policy, revised August 2015, stated, ". . . PROCEDURE A behavior management committee is formed to analyze the root cause(s) of a resident's behavior and provide alternatives to staff for solutions. It is designed as an interdisciplinary vehicle using the talents of staff across all shifts and disciplines. . . . Information and plans generated from this meeting will be used to update care plans on these residents on a more frequent basis than the traditional quarterly care plan. This will continue to assist the center to work with these residents and continue the problem-solving in this area can expand communications within the center, educate and assist all staff in understanding that the center is committed to managing these challenging residents. . . . Getting Started . . . 4. The main intent of the behavior management committee is to focus on only those residents with behavioral symptoms who are the most severe and persistent and to explore a variety of options for intervention and

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 223	Continued From page 3 treatment. . . ." - Review of Resident #1's medical record occurred on all days of survey and identified diagnoses of Parkinson's, hallucinations, history of falls, and depression. The MDS, dated 04/07/16, identified the resident with intact cognition, exhibited no behaviors, and transferred and ambulated independently. Current psychoactive medications included Seroquel XR (extended release) 12.5 mg three times daily and 25 mg at bedtime for hallucinations and Sertraline (Zoloft) 150 mg daily for depression. Observation on 06/21/16 at 11:40 a.m. showed Resident #1 leaving the dining room after eating less than 20% of her meal. The resident stated she was too upset to eat and asked to set up a time to speak with this surveyor. During a resident interview on 06/21/16 at 1:30 p.m. Resident #1 was tearful and stated the following: *She is afraid of Resident #9. She was so upset today, she was unable to eat lunch. *She feels anxious, depressed, and nauseous every morning as she dreads seeing him each day. *He blocks her path in the corridor with his walker. *He will bump the back of her legs with his walker and will poke her in the back with his finger. *He will sit on his walker outside her door and says he is "just checking things out." *He hollers at her and calls her names, such as "God damn old witch," "F**king old witch," "Old bitch," "Dumb Bitch," and "Slut bag."	F 223		

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F 223	Continued From page 4 *He will shuffle/stomp his feet or whistle to get her attention and then will say something like, "Bitch, Bitch, Bitch, Bitch, Bitch." *He is short-tempered, will stick his tongue out at her, raise his fist at her, or give her "the finger." *At times she is so scared, she asks staff to walk with her back to her room. *He has harassed her since he was admitted to the facility. They knew each other out in the community and he was mean to her then. *Administration tells her to avoid him, but he seeks her out and follows her. He will even follow her to the resident bathroom in the corridor by the dining room and will sit on his walker and wait for her a few doors down from the bathroom. *She feels like she is the one who is punished and has to change her routine when they have conflict. *She has told him to behave and leave her alone but it doesn't help. She has tried to stand up to him and not let him intimidate her and "give it back to him" but it doesn't work. Resident #1's current care plan stated, ". . . The resident has a psychosocial well-being problem R/T depression, hallucinations, memory impairment E/B behaviors towards others at times . . . Interventions . . . Remove resident to a calm safe environment and allow to vent/share feelings when conflict arises . . . Discuss resident's feelings as she desires . . . Provide assistance/supervision/support with identification of potential solutions to present problems . . . Provide assistance/encouragement/support to identify problems that cannot be controlled . . . Focus . . . The resident has a mood problem R/T memory impairment, depression, parkinsons, pain, hallucinations, restless legs E/B mood	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 223	Continued From page 5 fluctuates . . . short temper/easy annoyed at times . . . Intervention . . . allow/remind to rest. allow to vent. offer snacks. allow her to ask for other meal options. reassure. offer change of therapy time. offer activities in another area of the building . . . Focus . . . The resident has a behavior symptom R/T hallucinations E/B h/o rude/verbal behaviors towards others at time . . . Interventions . . . Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed . . . Provide opportunity for positive interaction, attention . . . If reasonable, discuss resident's behavior. Explain/reinforce to resident why behavior is inappropriate and/or unacceptable . . . has a scheduled time for therapy . . ." Review of Resident #1's interdisciplinary notes identified the following: *11/28/15 at 12:02 p.m. - "Resident was crying this am telling CNA that another resident [Resident #9] is calling her a red headed bitch and stubid [sic] bit--, and has been staring at her in the dining room. Will continue to monitor . . ." *06/01/16 at 8:45 a.m. - "[Resident #1] is upset that male resident [Resident #9] whom she dislikes was in the activity room folding towels. she does not want him in the same room as him [sic]. she was upset and left the room. she told this worker that he is 'ugly and he smells.' she said he was flicking her off with his middle finger and then laughing at her, also staring at her. staff state that she came in and was sitting with her back towards him, and none of the behaviors she reported him to be doing happened as they were watching carefully to observe any negative	F 223		

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F 223	Continued From page 6	F 223		

behaviors. she also states that he sits on his walker in the middle of the hall so she can't get around him. this has not been observed by this worker and this worker suggested that she says excuse me so he will move to one side of the hallway. to this suggestion she states she is not going to 'kiss his ass.' nurse from that side of building has only witnessed him to be in the middle of the hall at one point, but it was down the hall he resides and she does not reside down that hall nor are there activities down that hall. this worker reminded therapy staff to follow the therapy schedule, which they feel they do good at doing . . . she states she wants to 'kill him,' 'he is a bastard,' and she wants him out of her life."
*06/02/16 at 1:34 p.m. - "resident states that male resident [Resident #9] called her a bitch after lunch. Nobody heard name calling will continue to monitor."
*06/07/16 at 12:49 p.m. - "Res [Resident #1] was called a name by another resident [Resident #9]. Res. [Resident #1] did not argue back with the other resident [Resident #9] instead asking for DNS. Res [Resident #1] ambulated back to room, past the other resident [Resident #9] while the other tried to follow her. The other resident [Resident #9] was stopped by the DNS."
*06/08/16 at 4:24 p.m. - "resident is c/o [complaining of] that another mail [sic] resident [Resident #9] is following behind her after meals and is calling her names . . ."
*06/13/16 at 8:09 p.m. - "Res. stated to this nurse that she felt better today for the first time. She was pleased that the Staff believed her about another male Res. [Resident #9] being rude to her and calling her names . . ."
*06/15/16 at 2:18 p.m. - "Received fax (addressing gradual dose reduction for

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F 223	Continued From page 7	F 223		

antidepressant) from [name of medical provider] stating, I don't think we should adjust meds. Given difficult interactions with male resident (which are out of everyone's control), I would expect these reactions/behaviors. Continue to allow to vent and support emotionally."
*06/15/16 at 8:01 p.m. - "Resident spoke to this nurse today after supper saying that another male resident [Resident #9] has been following her after supper - she states he doesn't even finish his meal if he sees her leave he will throw off his cover-up and take off after her. He then will say mean and nasty curse words to her just low enough so that just she can hear. He also will try to scoot backwards on his walker suddenly cutting in front of her - causing her to either run into him or cause her to fall she isn't sure which he is trying to do." (Observation during survey identified Resident #1 with an unsteady gait as her lower extremities/shins rub together with each step.)

- Review of Resident #9's medical record occurred on June 22-23, 2016 and identified diagnoses of hypertension, diabetes, chronic pain, and depression. The quarterly Minimum Data Set (MDS), dated 05/18/16, identified the resident with intact cognition and "verbal" and "other" behaviors exhibited one to three days during the assessment reference period. The MDS showed the resident transferred and ambulated independently. Current psychoactive medications included Celexa 5 milligrams (mg) daily for depression.

Resident #9's current care plan stated, ". . . Focus: The resident has a psychosocial well-being problem potential R/T [related 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 _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 223	Continued From page 8 personality E/B [evidenced by] behaviors towards others at time . . . Interventions: Remove resident to a calm safe environment and allow to vent/share feelings when conflict arises . . . Discuss resident's feelings relative to: anger, rudeness . . . Focus: The resident has a mood problem R/T depression . . . short temper/easily annoyed . . . Interventions . . . encourage to express moods/feelings in appropriate way. encourage to attend activities of interest. allow to rest. reassure. offer snacks . . . offer pastor/chaplin visit. allow to vent. reassure . . . Focus: The resident has a behavior symptom R/T personality, preference, pain, DM [diabetes mellitus] E/B h/o [history of] . . . physical behaviors towards other, swear/make noises/curse/rude/offensive to others at times, stuck up middle finger at other resident, going against doctor orders, take medication off of nurses cart. verbal behaviors towards others in assessment period (scream/threaten). other behaviors not towards others (making disruptive sounds). has strong opinions/preferences . . . Interventions . . . Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed . . . Provide for positive interaction, attention. Stop and talk with him/her as passing by . .. Praise any indication of resident's progress/improvement in behavior . . . report behaviors to nurse/social worker as they occur, chart behaviors. encourage him to let staff handle problems with other [sic] rather then taking care of problems himself. remind to be patient. laundry/housekeeping staff may keep room door open while they are in his room. any staff may keep room door open, except while	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 223	Continued From page 9 doing cares . . . behaviors towards others: encourage to go to his room to calm down . . . encourage resident to express feelings/moods appropriately . . . Focus: . . . Does not get along with table mates has moved to different tables and he has a difficult time getting along with people at all tables, has moved in the dining room . . ." Review of Resident #9's interdisciplinary notes identified the following: *11/24/15 at 4:01 p.m. - "CNA states that on 11/20/15 [Resident #9] told one male resident 'you are the next fu**er to die' and called a Hispanic resident a 'spic' and that she couldn't sit at the table she was sitting at." *01/29/16 at 8:20 a.m. - "[Resident #9] came to this workers office stating he is 'sick of the bullshit' and threatening to throw a salt shaker across the room and hitting someone with it if people don't stop deliberately moving his condiments from where he wants them. I told him that that [sic] he can not be threatening violence because condiments are moved . . ." *03/10/16 at 4:30 p.m. - "Res. told this nurse: 'Your [sic] are not as tough as you think you are and I can do whatever I want to and you can do nothing about it.'" *03/25/16 at 8:00 a.m. - "resident entered the therapy room and was telling another resident to get off his bike. [Resident #9] was ramming his walker into the bike. I reminded him that it is not his bike. he commented that he knew that the other resident would be causing trouble. reminded him that there was not trouble in the room until [Resident #9] entered the room. [Resident #9] was told that he could either sit on another bike or wait patiently for the bike he was	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 223	Continued From page 10 arguing over. he was calling the other resident a 'son of a bitch,' stating 'I knew that son of a bitch would cause problems.'" *03/28/16 at 9:48 a.m. - "other resident states that [Resident #9] is telling him he looks like an alien from outer space because he has a headset on so he can hear better." *04/11/16 at 9:03 a.m. - "in therapy room being rude/teasing another resident about residents wife." *04/13/16 at 1:59 p.m. - "CNA reported that Res. mocked her and another Res. when they were communicating [sic] Spanish (that is Res. natural language). Also he stated, 'I am going to stand here until this Mexican [CNA] goes back to work.'" *04/18/16 at 3:00 p.m. - "Late Entry . . . CNA states [Resident #9] had followed her to opposite side of building to make rude comments to her and makes rude comments about her speaking Spanish to Hispanic resident at times." *05/06/16 at 6:00 p.m. - "This res. was seated backward in his walker and another res. was near him with her walker and he attempted to push as close to her as possible. The CNA told him to stop and watch out for others. He ignored the CNA and pushed ahead into his room." *05/13/16 at 6:25 p.m. - "CNAs were attempting to re-direct a female resident [Resident #1] back toward west hall where she resides. This resident [Resident #9] was coming down the hall beside her and talking to her, it is unclear what was said, but the female resident told [Resident #9] to mind his own business, no one likes him anyway, and that he was an asshole. He was asked to leave the area by a CNA, he would not leave, he stated he was trying to help. At last the female resident was re-directed with considerable effort, to talk	F 223		

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 _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 223	Continued From page 11	F 223		

about her grandkids and kids, and allowed staff to return her to her room. [Resident #9] was still sitting in the area during this process. He had been asked several times to leave the area."
*05/18/16 at 3:08 p.m. - "CNAs and nurse visiting with this worker. state that [Resident #9] is sneaky in his behaviors. they have seen him try to trip others at times, sticking his foot out to the side to try to get them to trip. CNA states that on Monday he was banging on the table with a fork/spoon because he wanted to get his food before everyone else and not wait. the CNA told him to stop and that he needs to wait but the kitchen did serve him. CNA hopes that he doesn't continue to bang his silverware. after being told this, this worker talked to him and told him that the behavior could not continue and he only smiled at this worker.
CNA said a week or two ago [Resident #9] was trying to push a female resident into the wall of the hallway by getting closer and closer to her as she was walking with her walker. He did not touch her or her walker, but CNA felt he was getting close and pressuring her into walking into the side of the wall. CNA stopped him before female walked into the wall."
*06/07/16 at 12:18 p.m. - "Res upset this morning as did not want to follow restorative room schedule because the other res [Resident #1] on schedule was not there yet due to a bath. Argued and then stated, 'you are not the boss anymore' meaning the other res is. Tried to re-educate about the schedule and last weeks problems when this resident went in early on other res. time. Res. left the area. After dinner an aide called me to the dining room. This res was calling the other resident a 'dumb ass' a number of times and the other res. wanted to speak with me. DNS

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 _____	06/23/2016

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 223	Continued From page 12 [director of nursing services] walked with the other res past the doorway this res was sitting in. At this point, this resident stood up and wanted to leave, res. walker held up by DNS until other resident could turn at the end of the hallway. Res. insisted he needed the toilet really bad but when allowed to go, started a slow run and turned the other residents way, not his own. Stopped but his walker rested gently at the back on her legs. Other resident did leave area. This resident continued to argue 'you are not the boss' meaning once again the other resident was the boss. Res. then walked back towards dining room area . . ." *06/07/16 at 1:15 p.m. - "in therapy room in front of other residents stating he is going to 'skin the red headed bitch' because he was upset that he wasn't allowed in therapy this morning at the 8 oclock hour. other residents appeared uncomfortable. he was asked to leave if he was going to continue to talk like that. didn't leave but then calling her 'the boss.'" *06/08/16 at 11:07 a.m. - "this morning [Resident #9] went in therapy before other residents. stated he was 'resting.' was asked by RT to leave and he refused to leave. knowing it was not his assigned week to be in therapy at the 8 am hour. female resident went into the RT room. [Resident #9] had left the room and called her a rude name when she was walking in the room. he then called names/rude to her during her therapy. [Resident #9] then went into activity room while Administrator walked by, then [Resident #9] went into the therapy room . . . [Resident #9] was continually asked to leave. [Resident #9] also harassing RT and telling her she isn't the boss. after some time he did leave. female was offered to have staff walk with her after that and chose	F 223		

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 _____	06/23/2016

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 223	Continued From page 13 not to have that done, and went to a friends room." *06/13/16 at 12:20 p.m. - "[Resident #9] went into RT room while female resident who he is not to be in there with is exercising. he had already exercised this morning in RT. he states he is always in there in the afternoons and mornings. that is not so. he is calling the female resident names. this worker as well as DON and RT aide asked him to leave the room. he argued and name called longer before leaving the room. DON and I visited with him in activity room and told him his new time in therapy is only in the afternoons. this was discussed with him last week if he would cause further problems in the RT room that would be his new time. he was also made a sheet as well as a sheet for the RT room that states he is only to be in the RT in the afternoons with RT present." *06/13/16 at 12:33 p.m. - "sheet states 'Therapy only in the afternoon with RT aide present.' this worker knocked on his door, he allowed this worker into the room. he was sitting in his recliner with walker in front on him. this worker laid the sheet on his walker and he yelled to 'get out, get out' as this worker was leaving his room he took the sheet and crumpled it into a ball and threw it at this worker . . ." *06/14/16 at 8:13 a.m. - "resident in therapy room at 8 am and refusing to leave the room. administrator, sw [social worker], and rt all asking him to leave nicely. he was rude, calling names, swearing, saying these staff are not Christian or the boss, and he will not listen to women. He did eventually leave the room after stating he will contact his lawyer and will not come to therapy anymore. the name calling and talking back continued down the hallway for sometime.	F 223		

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 _____	06/23/2016

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 223	Continued From page 14	F 223		

administrator and sw apologized to other residents in the rt room after the incident was finished."
*06/15/16 at 7:57 p.m. - "Reported to this nurse from CNAs that they have observed [Resident #9] after supper following another female resident [Resident #1] to nurses station. He waits for her and then is noted saying things quietly to her - he also will try to block her as she is walking down the hall. Staff is able to intervene and sent [Resident #9] down his hall where room is located."
*06/17/16 at 9:30 a.m. - "behavior meeting met. continued having behaviors in therapy. has been moved to afternoons for his scheduled therapy time for now. RT will also invite him into therapy when he isn't coming due to being upset with this new schedule. Will follow female resident in halls as well. Will continue to monitor."

During a resident interview on 06/22/16 at 4:52 p.m., Resident #9 stated he has a problem with one resident here, [Resident #1]. He stated, "she thinks she is the boss and hates herself and everyone else, including me." Resident #9 stated, "She starts screaming if I even look at her and I don't do nothing to her." The resident denied calling Resident #1 names, blocking her path, etc. He stated they never got along in the community, either. Resident #9 stated he refuses to avoid her - "she needs to get over it."

During an interview on 06/21/16 at 5:00 p.m., a staff nurse (#10) stated Resident #9 targets Resident #1 and is intentionally mean to her. He blocks her path, calls her names, and tries to upset her and make her cry. The nurse (#10) stated the conflict is ongoing and nothing helps

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 _____	06/23/2016

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 223	Continued From page 15	F 223		

the situation. The nurse (#10) stated Resident #9 is also angry, irritable, rude, and verbally abusive to other residents, staff, and visitors, as well.

During an interview on 06/22/16 at 2:35 p.m., regarding the ongoing conflict between Resident #1 and Resident #9, a social services staff member (#11) stated in July 2015 they attempted to schedule the residents' therapy at different times, rotating at 8:00 a.m. each week. Resident #3 also didn't want to go to therapy at the same time as Resident #9, so now Resident #1 and Resident #3 have therapy in the mornings and Resident #9 in the afternoons. The staff member (#11) stated things had gotten better with Resident #1 and Resident #9 up until the last couple of weeks. When asked what the facility has done to address Resident #9's behaviors, the staff member (#11) stated "this is his personality" versus a behavior, and identified the resident would also cause problems in the community prior to his admission. She stated things are better with Resident #9 when things are done his way. The staff member (#11) stated interventions used to address Resident #9's conflict with others include switching dining room tables, talking to him to calm him down, getting the ombudsman involved last summer, and switching the therapy schedule. She stated Resident #9 intimidates other residents in the therapy room just by being in there sometimes, even when he isn't causing problems. She did identify Resident #9 will focus on one resident and right now it is Resident #1. The social services staff member (#11) identified Resident #1 asked her to walk her to her room this afternoon and past Resident #9 and Resident #9 called her (staff member #11) a "crooked Hillary"

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 _____	06/23/2016

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 223	Continued From page 16	F 223		

and a "mosquito" (since she is always around). She stated Resident #9 can be nice and his moods are a "rollercoaster." The staff member (#11) stated Resident #1 and Resident #9 are both guilty of instigating conflict and not all things Resident #1 says Resident #9 says or does to her is witnessed by staff.

During an interview on 06/22/16 at 5:50 p.m., an administrative nurse (#13) stated the facility has "tried everything" to address Resident #9's behaviors towards other residents. The nurse (#13) stated the ombudsman has been involved, other facilities won't take him, Resident #9 is his own responsible party and refuses psychiatric consults and/or medications. She stated, "We can't kick him out." The administrative nurse (#13) stated Resident #9's medical provider is aware of the behaviors and thinks his non-compliance with medications and medical treatment resulting in high blood sugars contribute to his behaviors. The staff member (#13) stated, "[Resident #1] has hallucinations and sees bugs - can't believe everything she says."

- Review of Resident #3's progress notes occurred on all days of survey. A progress note dated 11/08/15 at 11:48 a.m. stated, ". . . while sitting in w/c waiting for breakfast at 730 am, another resident [Resident #9] approached this resident and hit his legs three times with his FWW, stating 'he stole his place in [dining room]', this res did nothing to provoke the other and did admit wanting to hit him back but didn't; staff was present for entire incident and prevented any further actions although other resident continued to verbally harass him and yell rude remarks 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 _____	06/23/2016

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 223	Continued From page 17	F 223		

this man; no injury found from incident then or at this time . . ."

Review of Resident #3's current care plan stated, ". . . Focus . . . The resident has a behavior symptom R/T Alz [Alzheimer], dementia, anxiety, psychosis, . . . e/b h/o wanders at times. h/o rejects cares at times, exit seeking in assessment period. . . . Interventions . . . threatening others: attempt to keep [Resident's name] from [Resident #9]."

During an interview on 06/22/16 at 5:10 p.m., an administrative staff member (#11) stated she was aware of the conflict between Resident #3 and Resident #9 and the only interventions in place was to keep the two residents separated while in the therapy room.

- During a resident interview on 06/21/16 at 4:40 p.m., Resident #10 [identified by the facility as interviewable] stated the following:
* "[Resident #9] used to pick on me and make me feel afraid he was going to hurt me. He would get up to my face very close."
* "[Resident #9] now picks on other people in the facility so he has left me alone. He is very nasty to everybody not just one person."
* "[Resident #9] shouted out loud across the therapy room to remove my wig and show all the men you are bald headed."
* "[Resident #9] yelled across the room at me that I was not allowed to sit in a chair. It made me very afraid."

During an interview on 06/22/16 at 5:10 p.m., a social services staff member (#11) stated she was aware of the conflict between Resident #9

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 _____	06/23/2016

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 223	Continued From page 18 and Resident #10 and confirmed the facility did not care plan interventions as Resident #10 reported these issues months after the incidents happened. - During a resident interview on 06/22/16 at 4:05 p.m., Resident #21 stated she used to have problems with [Resident #9] about two years ago. He would call her names, push her "cart" (walker), flip her off, say "dirty" things. Resident #21 stated they get along fine now and he currently picks on others, especially Resident #1.	F 223		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to complete a significant change in status assessment (SCSA)	F 274	1. This tag indirectly affected Resident # 3 and Resident # 4. The care plans had been updated at that time to reflect the decline of status of each.	7/28/16

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 _____	06/23/2016

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 274	Continued From page 19 for 2 of 12 sampled residents (Resident #3 and #4) after a significant change in the resident's condition. This limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate care approaches. Findings include: The Long-Term Care Facility RAI User's Manual Version 3.0, October 2015, pages 2-20 and 2-23 stated, ". . . A 'significant change' is a decline or improvement in a resident's status that 1. Will not normally resolve itself without intervention . . . (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g. [example given], two areas of ADL [activities of daily living] decline or improvement). . . ." Review of the facility policy titled "MDS 3.0 (Minimum Data Set)/RAI (Resident Assessment Instrument)" occurred on 06/23/16. This policy, dated April 2016, stated, ". . . Procedure: 1. When a significant change is identified, the professional staff member identifying the change will notify the social worker, RN [registered nurse] coordinator or designated staff member so that a timeline may be established and communicated to team members. 2. The team member who identified the change will document . . . that a significant change has occurred and will identify whether the change is an improvement or a	F 274	2. This tag has the potential to affect all residents. 3. The interdisciplinary Team will be educated on 7/20/2016 with CMS□s Medicare-Required SNF PPS Assessments, Page 5, Significant Change in Status Assessments reviewing the guidelines for a Significant Change. The team will meet weekly to discuss any changes in resident□s statuses -improvement or decline in health noted from MDS to the MDS currently being worked on. If significant changes are identified, the MDS will be changed to a Significant Change in Status Assessment. 4. An audit will be conducted on residents whose MDS is scheduled at the time of the audit on any areas that changed from the previous MDS and see if a Significant Change in Status Assessment needs to be completed. Audit will be done weekly x4, monthly x2, quarterly x3 and then as deemed necessary by the QA committee. Audit will be completed by the QA coordinator or designee and reviewed by the QA committee.	

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 _____	06/23/2016

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 274	Continued From page 20 decline and in what areas. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia, Alzheimer's disease, history of falling, pain, fatigue, and depression. Review of an admission MDS, dated 06/22/15, identified the resident required limited assistance of one person with dressing and toileting. The quarterly MDS, dated 09/14/15, identified the resident required extensive assistance of one person with dressing and toileting, and limited assistance of one person walking in corridor and personal hygiene. The quarterly MDS, dated 12/14/15, identified the resident required extensive assistance of one person with walking in corridor and personal hygiene. The medical record lacked evidence staff completed a SCSA following Resident #3's decline in ADL's for two consecutive quarterly MDSs, dated 09/14/15 and 12/14/15. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included unsteadiness on feet, muscle weakness, Alzheimer's disease, dementia, and shortness of breath. Review of a quarterly MDS, dated 12/26/15, identified the resident required limited assistance with bed mobility, and transfers, and extensive assistance with toileting. The quarterly MDS, dated 03/10/16, identified the resident required extensive assistance with bed mobility and transfers, locomotion on and off the unit, and toileting.	F 274		

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 _____	06/23/2016

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 274	Continued From page 21 The quarterly MDS, dated 06/05/16, identified the resident required extensive assistance with bed mobility, transfers, walk in room, and toileting. The medical record lacked evidence staff completed a SCSA following Resident #3's decline in ADL's for the quarterly MDS, dated 03/10/16. The facility failed to provide documentation that a SCSA was not going to be initiated after hospitalization. During an interview on 6/22/16 at 4:20 p.m., a staff member (#12) confirmed the facility should have completed a SCSA.	F 274		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual	F 278		7/28/16

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 _____	06/23/2016

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 22 to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. 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 Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.13), and staff interview, the facility failed to ensure the Miniumum Data Sets (MDSs) accurately reflected the resident's status for 3 of 12 sampled residents (Resident #3, #4, and #11). Failure to accurately code delusions and behaviors on the MDS does not provide an accurate assessment of the resident's current status and needs. Findings include: The Long-Term Care Facility RAI User's Manual , revised October 2015, stated: * pages 1-8: ". . . While CMS [Centers for Medicare and Medicaid Services] does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS.	F 278	1. This tag directly affected residents #3 (ARD 4-4-16), #4 (ARD 10-30-2016 and 6 -5-2016), and #11 (ARD 4-18-16 and 6-15 -16). Except for Resident #11, ARD of 6-15-16 a modification was done, after discovering the miscoding during the care conference on 6/23/16. 2. This tag has the potential to affect all residents. 3. The Social Worker was educated on July 20, 2016 with CMS□s RAI version 3.0 manual Section E: Behavior. All dates of sources and behaviors that are coded on the MDS will be documented by LSW. 4. An Audit will be done on the coding of behaviors and the sources weekly x4, monthly x2 and quarterly x3 and as deemed necessary by QA committee. Audits will be completed by the QA coordinator or designee and reviewed by the QA committee.	

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 _____	06/23/2016

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 As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. . . ." * pages E-1 to E-2: "Delusion: A fixed false belief not shared by others that the resident holds even in the face of evidence to the contrary. . . . When a resident expresses a clearly false belief, determine if it can be readily corrected by a simple explanation of verifiable (real) facts (which may only require a simple reminder or reorientation) or demonstration of evidence to the contrary. . . . Check E0100B, delusions: if delusions were present in the last 7 days. . . ." * page E-4: ". . . E0200: Behavioral Symptom -Presence and Frequency . . . A. Physical behavioral symptoms directed toward others (e.g. hitting, kicking, pushing, scratching, grabbing, abusing others sexually) B. Verbal behavioral symptoms directed toward others (e.g. threatening others screaming at others, cursing at others) C. Other behavioral symptoms not directed toward others (e.g. physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) . . ." - Review of Resident #3's medical record occurred on all days of survey. An annual MDS, dated 04/04/16, identified the resident displayed other behavioral symptoms 1 to 3 days during the 7-day assessment period. The medical record lacked documentation of the behaviors demonstrated by Resident #3 during the	F 278		

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 _____	06/23/2016

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F 278	Continued From page 24 assessment period. - Review of Resident #4's medical record occurred on all days of survey. An annual MDS, dated 10/30/15, identified the resident displayed verbal and other behavioral symptoms 1 to 3 days during the 7-day assessment period. A quarterly MDS, dated 06/05/16, identified the resident experienced delusions during the 7-day assessment period. Resident #4's medical record lacked evidence of the resident experiencing delusions and behaviors during the assessment period. - Review of Resident #11's medical record occurred on June 22-23, 2016. An admission MDS, dated 04/18/16, identified the resident displayed other behavioral symptoms 1 to 3 days during the 7-day assessment period. A quarterly MDS, dated 06/15/16, identified the resident displayed physical, verbal, and other behavioral symptoms 1 to 3 days during the 7-day assessment period. The medical record lacked documentation of the physical, verbal, or other behaviors demonstrated by Resident #11 during the assessment period. During an interview on 06/22/16 at 4:37 p.m., an administrative staff member (#11) confirmed Resident #3, #4, and #11's medical record lacked documentation regarding delusions and behaviors during the assessement period.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		7/29/16

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F 309	Continued From page 25 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 06/24/15. Based on observation and manufacturer guidelines, the facility failed to ensure administration of insulin occurred within the recommended times for 2 of 3 supplemental residents (Resident #15 and #16). This failure placed individual residents at risk for low blood sugar (hypoglycemia). Findings include: Review of the manufacturer insert for NovoLog Mix 70/30 titled "NovoLog Mix 70/30", occurred on 06/22/16. The insert, dated February 2015, stated, "Patient information . . . do not not inject NovoLog Mix 70/30 if you are not planning to eat within 15 minutes . . . Administration . . . The dose of insulin required to provide adequate glycemic control for one of the meals may result in . . . hypoglycemia . . . Severe hypoglycemia may lead to unconsciousness and/or convulsions and may result in temporary or permanent impairment of brain function or even death . . . " - Observation of medication pass on 06/20/16 at 5:05 p.m. showed a nurse (#9) administered 20 units of NovoLog Mix 70/30 insulin to Resident	F 309	1. Resident #16 has been discharged to home. Resident #15'□s insulin has been changed to long acting per primary care provider. This was done on 7/14/16 after the blood sugars and meds were reviewed and the Licensed Pharmacist consulted. 2. All residents on short-acting insulin□s have the potential to be affected by this tag. 3. Education to Licensed Nursing Staff will be given on July 20, 2016 on the Policy and Procedure Hypoglycemic Incidents and the Manufacturer□s insert from NovoLog and NovoLog 70/30 for the specific time frame of eating within 15 minutes of administration. All residents on short acting insulin□s will have their plan of care reviewed to consider long acting insulin vs. the short acting. All residents needing the short-acting insulin after MD review and Pharmacy consult will continue on it as ordered, and have food within the 15 minute requirement or immediately after the meal based on the manufacturer□s insert and an area will be set up in the lounge area to assist with being able to give the insulin less than 15	

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F 309	Continued From page 26 #16. The resident began eating at 5:47 p.m. (42 minutes after staff administered insulin). - Observation on 06/21/2016 at 5:11 p.m. showed a licensed nurse (#2) administered NovoLog Mix 70/30 to Resident #15, who began eating 22 minutes after administration at 5:32 p.m. - Observation of medication pass on 06/21/16 at 5:15 p.m. showed a nurse (#10) administered 20 units of NovoLog Mix 70/30 insulin to Resident #16. The resident began eating at 5:40 p.m. (25 minutes after staff administered insulin).	F 309	min before eating. All other staff will be educated on not assisting insulin depend residents to the table before insulin is administrated. 4. An audit will be conducted on residents who are insulin dependent and receive a short acting insulin to insure they are not getting their insulin longer than 15 min of eating. Audit will be done weekly x4, monthly x2, quarterly x3 and then as deemed necessary by the QA committee. Audit will be completed by the QA coordinator or designee and reviewed by the QA committee.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: WATER TEMPERATURES 1. Based on observation, review of facility water temperature records, and staff and resident interview, the facility failed to ensure acceptable temperatures for hot water for 2 of 2 resident care units (East and West) and 1 of 1 dining room. Failure to maintain acceptable temperatures may result in residents and/or staff	F 323	Water Temps 1. This tag did not directly affect any residents or staff. 2. This tag has the potential to affect all residents and staff. 3. The Maintenance Man was verbally educated by the Administrator during the	7/28/16

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F 323	Continued From page 27 receiving burns. Findings include: On 06/20/16 at 11:57 a.m. a surveyor washed her hands at the sink in the dining room and noted the water felt hot. Observation showed the sink identified as the "Eyewash" station. Observation of water temperatures on the East and West units occurred on - 6/20/16 from 2:55 p.m. to 3:06 p.m. and showed the following temperatures: Dining room/eye wash station: 123 degrees Fahrenheit (F) Room 205: 116.6 F Room 206: 119 F Room 212: 115.7 F Room 305: 107.9 F Room 310: 120.8 F West wing family room: 119.9 F Room 407: 124 F Room 507: 120.4 F Room 608: 124.3 F Room 704: 123 F During an interview on 06/20/16 at 3:05 p.m., a Certified Nursing Assistant (CMA) (#5) stated the water "sometimes gets hot if we let it run a long time." On 06/20/16 at 3:05 p.m. the survey team notified the administrator (#4) of the water temperatures. On 06/20/16 at 3:20 p.m., the administrator (#4) provided the facility's "Water Temperature / Hardness Record" which showed the following temperature ranges in residents' rooms:	F 323	days of survey and water temps tested several times. Formal education will be provided to the Maintenance Man on July 20, 2016 with the Policy and Procedure Domestic Water Temperatures. Maintenance man will continue his schedule of weekly testing as previously done. If an adjustment is made, retest the temp, record as such and give documentation to Administrator or QA coordinator. 4. An audit will be conducted to ensure Water Temps remain at an acceptable range. Audit will be done weekly x4, monthly x2, quarterly x3 and then as deemed necessary by the QA committee. Audit will be completed by the QA coordinator or designee and reviewed by the QA committee. Chemicals 1. This tag did not directly affect any residents. 2. This tag has the potential to affect all residents. 3. Housekeeping staff were verbally educated by Administrator and DNS during the days of the survey. A meeting on July 20, 2016 will review the risks of chemicals in resident areas. 4. Each cart has been marked with a number to identify it during auditing and an audit will be conducted for the presence of chemicals on top of the carts,	

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F 323	Continued From page 28 03/25/16: 111 F to 113 F 04/29/16: 119 F to 120 F - the record showed staff reset the water heater to 115 F 05/31/16: 110 F to 111 F On 06/20/16 from 4:50 p.m. to 5:42 p.m. a recheck of water temperatures in the above residents' room showed temperatures ranged from 101 F to 105.8 F and showed the dining room sink at 115.2 F and the West family room at 101.1 F. During individual resident interview conducted on June 20-23, 2016, Resident #1, #5, #7, and #10 (identified by the facility as interviewable) expressed no concerns with water temperatures. A resident group interview, conducted on the afternoon of 06/21/16, failed to identify concerns with water temperatures. During an interview on 06/21/16 at 4:30 p.m., an administrator (#4) stated the facility was working to adjust temperatures due to resident concerns that the water was cold in the tub rooms that morning. HAZARDOUS CHEMICALS 2. Based on observation, review of Material Safety Data Sheets, and staff interview, the facility failed to ensure an environment free of accident hazards on 2 of 2 resident care units (East and West). This failure placed cognitively impaired residents residing on the units at risk of an injury. Findings include:	F 323	all janitor closets, and soiled utility rooms will be check to ensure hazardous chemicals are not accessible to residents. Audit will be done weekly x4, monthly x2, quarterly x3 and then as deemed necessary by the QA committee. Audit will be completed by the QA coordinator or designee and reviewed by the QA committee.	

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F 323	Continued From page 29 Review of Material Safety Data Sheets, on 06/23/16, identified the following: * Virex 256: "Danger. Corrosive. Causes skin and eye burns. Harmful or fatal if swallowed. Combustible liquid and vapor." * Clorox: Moderate eye irritant. Mild to moderate skin irritant . . . Do not get in eye or on clothing. Avoid prolonged or repeated skin contact. Avoid prolonged breathing of vapor. Use only in well-ventilated areas." * Glance NA Glass and Multi-purpose cleaner: "May be mildly irritating to eyes. May be mildly irritating to eyes . . . Avoid contact with skin and eyes." * Stride Citrus Neutral Cleaner: "May be mildly irritating to skin. May be mildly irritating to eyes . . . Avoid contact with skin and eyes." * Lysol IC Disinfectant Foam Cleaner: "Skin. Prolonged or repeated contact may cause irritation . . . Eyes. May cause irritation . . .Immediately flush eyes thoroughly with water . . ." - Observation on the morning of 06/21/16 showed the following chemicals on the top shelf of unattended cleaning carts: * 9:42 a.m.: East unit cart - Lysol IC, Clorox Clean Up, Glance NA, Stride 51, and Virex 256 * 10:00 a.m.: Two West unit carts - Virex 256 and Clorox Clean Up * 10:30 a.m.: East unit cart - Glance NA, Virex 256, and Stride 51 During an interview on 06/21/16 at 10:05 a.m. an administrative nurse (#1) stated cleaning staff should not leave chemicals unattended on the carts.	F 323		

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F 323	Continued From page 30 - A tour of the environment occurred on the morning of 06/22/16 with a maintenance staff member (#6). Observation during the tour showed the following: * 8:15 a.m.: An unlocked janitor closet in the 800 hallway with a cup filled with unidentified pink liquid under a spout of the chemical dispenser * 8:20 a.m.: an unlocked soiled utility room on the East wing with a container of Clorox Clean Up in an unlocked cupboard. During the tour, the staff member (#6) stated staff are expected to store the above chemicals in locked areas.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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.	F 431		7/28/16

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F 431	Continued From page 31 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer guidelines, and staff interview, the facility failed to date inhalers on 1 of 2 nursing units (West). This practice may affect the potency and efficacy of the medication. Findings include: Review of the manufacturer insert for Advair Diskus titled "Highlights of prescribing information" occurred on 06/23/16. The insert, dated April 2014, stated, "... Discard ADVAIR DISKUS 1 month after opening the foil pouch or when the counter reads "0"...whichever comes first..." Observation of the west unit #1 medication cart on 06/23/16 at 9:09 a.m., showed Resident #19 and #20's Advair Diskus inhalers removed from the manufacturer foil pouch, undated. The licensed nurse (#2) stated she did not know staff needed to date Advair Diskus once opened from the foil pouch.	F 431	1. This tag did not directly affect any resident. 2. This tag has the potential to affect all residents on Advair. 3. All inhalers in the building are dated at present (6-30-2016). Nurses were verbally educated by DNS during the days of survey to date all Advair when opened and destroy after 30 days. Formal education will be given to all Nurses and Med. aides on July 20, 2016 with review of the package insert of the Advair medication for the destruction of medication as required. 4. An audit will be conducted to ensure open dates on all Advairs in the building. Audit will be done weekly x4, monthly x2, quarterly x3 and then as deemed necessary by the QA committee. Audit will be completed by the QA coordinator	

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GOOD SAMARITAN SOCIETY - OAKES	213 N 9TH ST OAKES, ND 58474

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F 431	Continued From page 32 Observation of the west unit #2 medication cart on 06/23/16 at 9:25 a.m., showed Resident #18's and another unidentified resident's Advair Diskus inhaler removed from the manufactures foil pouch, undated. A licensed nurse (#3) stated she did not know staff needed to date Advair Diskus once opened from the foil pouch. During an interview on 06/23/16 at 10:05 a.m., an administrative nurse (#1) stated she expected staff to follow manufacturer guidelines for dating Advair Diskus when opened.	F 431	or designee and reviewed by the QA committee.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		7/28/16

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	355095	A. BUILDING _____ B. WING _____	06/23/2016

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F 441	Continued From page 33 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff appropriately handled linen in 1 of 1 facility laundry. Failure to wear protective garments when sorting soiled linen may result in contamination of clean linen. Findings include: A tour of the environment occurred on the morning of 06/22/16 with a member of the maintenance staff (#6). Observation in the facility laundry at 8:10 a.m. showed no protective equipment available in the soiled laundry room. When interviewed during the tour, laundry staff members (#7 and #8) stated gowns are available, however, they do not wear them when sorting soiled linen and wear the same uniforms worn in the soiled linen room when working in the clean linen room. Failure to ensure staff wore the available	F 441	1. This tag did not directly affect any resident. 2. This tag has the potential to affect all residents. 3. Laundry staff was verbally educated during the days of survey by the Administrator. A meeting is scheduled for July 20, 2016 to educate all staff on wearing protective garments when sorting soiled linen, and if not wearing, can result in contamination of their uniforms and spread of infection within the facility. 4. An audit will be conducted to observe Laundry staff during the sorting of linen to ensure protective garments are worn. Audit will be done weekly x4, monthly x2, quarterly x3 and then as deemed necessary by the QA committee. Audit	

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F 441	Continued From page 34 protective garments when sorting soiled linen may result in contamination of the their uniforms and spread of infection within the facility.	F 441	will be completed by the QA coordinator or designee and reviewed by the QA committee.	