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 _____	06/24/2015

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

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 06/22/15 and completed on 06/24/15, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included three (3) additional residents to verify specific concerns during the survey.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to assess the safety of self-administration of medication (SAM) for 1 of 1 supplemental resident (Resident #17) observed with medications left at the dining room table. Failure to determine if SAM is a safe practice has the potential to result in a medication error and/or harm to a resident. Findings include: Review of the facility policy titled "ADMINISTRATION OF MEDICATION" occurred on 06/24/15. This policy, revised 11/14, stated, ". . . PROCEDURE . . . 12. Do not leave medications at the bedside or at the table unless there is a specific physician order to do so. If the	F 176	Self-Administration Medication 1. Resident #17s individual needs have been addressed by asking her if she wants to self-administer medications. She stated she doesn't wish to self-administer medications at the meal table. A progress note was entered 7/20/15. The nurse will administer her medications per procedure. 2. All residents that verbalize the wish to self-administer medications have the potential to be affected in this area. A list of residents who self-administer medications will be generated and reviewed for a SAM UDA and physician order.	7/29/15

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

Electronically Signed | 07/23/2015

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F 176	Continued From page 1 resident has not been assessed for safety of self-administration, and there is not a physician order to leave the medication with the resident, you must stay with the resident until the medication is taken. . . ." Observation on 06/23/15 at 7:49 a.m. during the morning medication pass showed a nurse (#12) leave Resident #17's medications at the dining room table. The nurse (#12) signed off the medications on the medication administration record before ensuring the resident took all of the medications. Review of Resident #17's medical record occurred on 06/24/15. The quarterly Minimum Data Set, dated 05/24/15, identified the resident as cognitively intact. Resident #17's medical record lacked a SAM assessment. During an interview on 06/23/15 at 4:34 p.m., a managerial nurse (#3) confirmed Resident #17 is unable to self-administer medications.	F 176	3. Mandatory Nursing in-service on 7/23/15 to review procedure titled "SAM" with a focus on the need to have the nurse assess resident for a "SAM" UDA and have a physician's order for all medications that are self-administered. Resident education on keeping the medications safe from other residents at the meal table. 4. An audit will be developed to monitor compliance in "SAM". The audit will be completed weekly for four weeks, then monthly for two months and then quarterly times 1 or as deemed necessary by QA committee. The DNS or designee is responsible for the completion of the audit. Results of the audit will be reported to the QA committee for further recommendations.	
F 225 SS=B	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225		7/29/15

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F 225	Continued From page 2 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 11/12/14. INVESTIGATE BRUISES 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to implement policies regarding abuse/neglect for 1 of 1 sampled resident (Resident #3) observed	F 225	Investigating Bruise 1. 6/23/15 bruises were found on resident #3¿s arm during survey. An incident report and investigation was completed on 6-25-15. Was reported to the state on 6/29/15. Resident#3 has been evaluated and care plan has been revised to include daily monitoring of skin.	

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F 225	Continued From page 3 with bruises of unknown origin. Failure to implement the facility's written abuse prevention policies and procedures and ensure a thorough investigation placed all residents at risk for abuse and mistreatment. Findings Include: Review of the facility policy titled "Abuse and Neglect" occurred on 06/24/15. This policy, revised September 2013, stated, ". . . Alleged or suspected violations involving any mistreatment, neglect or abuse including injuries of unknown origin will be reported immediately to the center administrator and to other officials in accordance with state law, including the state survey and certification agency. . . . The center will have evidence that all alleged or suspected violations are thoroughly investigated . . . Results of all investigations will be reported . . . including to the state survey and certification agency within five working days of the incident . . ." Review of the facility procedure titled "Abuse and Neglect" occurred on 06/24/15. This policy, revised 06/14, stated, "PURPOSE: *To ensure that the center has in place an effective system that, regardless of the source, prevents mistreatment, neglect and abuse of residents or misappropriation of their property . . . *To ensure that all identified incidents of alleged or suspected abuse/neglect are promptly investigated and reported *To ensure that all identified incidents involving injuries of unknown origin are promptly investigated to determine probable cause of unknown origin injuries . . . *To ensure that a complete review of existing incidents is documented *To identify events, such	F 225	2. All resident with bruises of unknown origin have the potential to be affected in this area. 3. Mandatory Nursing in-service on 7/23/15 to review procedure titled "Abuse Reporting" with a focus on the need to report ALL bruises of unknown origin to the ND DOH within 24 hours and a follow up investigation summary to the state within 5 days of incident. 4. Audit will be completed to ensure compliance in incident/accident /misappropriation of resident property/funds. The Audit will be to monitor 24/72 hour progress notes for incidents bruises of unknown origin, whether the ND DOH was notified within 24 hours of the initial report and if the state reporting agency was informed within 5 days with a conclusion and action taken to prevent the reoccurrence. The audit will be completed weekly x 4, then monthly x2 and then quarterly x1 or as deemed necessary by QA committee. The DNS or designee is responsible for the completion of the audit. Results of the audit will be reported to the QA committee for further recommendations	

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F 225	Continued From page 4 as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse and to determine the direction of the investigation . . ." Review of Resident #3's medical record occurred on all days of survey. The current Minimum Data Set (MDS), dated 05/29/15, identified moderately impaired cognition and extensive assist of two or more staff with transfers. Observation on 06/22/15 at 4:45 p.m. showed Resident #3 seated in a wheelchair. Resident #3 had scattered reddish/purple bruises on her right and left arms near the elbows. Observation on 06/23/15 at 10:15 a.m. showed Resident #3 received a shower. Resident #3's medical record lacked documentation that the bath CNA reported the resident's bruises. Resident #3 stated, "I went to bed one night and when I got up the next morning I had these." (pointing to bruises) During an interview on the morning of 06/24/15, a supervisory nurse (#2) stated staff failed to document/investigate Resident #3's bruises. REPORT ALLEGATIONS 2. Based on review of facility policy, and review of abuse/neglect investigations, the facility failed to report 2 of 3 alleged incidents (incidents on 12/07/14 and 02/14/15) of abuse/neglect immediately to the State survey and certification agency and failed to report the results of their investigations by the fifth day to the State survey and certification agency. Failure to report and	F 225		

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F 225	Continued From page 5 thoroughly investigate all alleged violations has the potential to place all residents at risk of possible abuse/neglect. Findings include: Refer to facility policy under Base #1. Review of investigations of alleged abuse and neglect incidents occurred on 06/24/15 at 10:03 a.m. with an administrative staff member (#21) and revealed the following: * The "Report of Missing Item" form identified an incident occurred on 12/07/14 (Sunday). An e-mail showed the facility notified the State survey and certification agency on 12/09/14 (Tuesday), two days after the incident. The facility failed to immediately report the misappropriation of property to the State survey and certification agency and report the results of the investigation by the fifth day. * The "Injury Report" form identified an incident occurred on 02/14/15 (Saturday). An e-mail showed the facility notified the State survey and certification agency on 02/18/15 (Wednesday), four days after the incident. The facility failed to immediately report the allegation to the State survey and certification agency.	F 225		
F 278 SS=E	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.	F 278		7/29/15

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F 278	Continued From page 6 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 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 Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 6 of 13 sampled residents (Resident #1, #2, #7, #10, #12, and #13) coded incorrectly on the MDS. Failure to code portions of the MDS correctly does not provide an accurate assessment of the resident's current status and needs and may prevent staff from developing an effective comprehensive care plan that meets the needs of the residents.	F 278	Care Plan/MDS 1. Residents 1 expired on 7-12-15. Resident 2 current turning/repositioning reviewed. Quarterly MDS and Care Plan were corrected on 7/3/15 to remove turning/repositioning program due to resident is receiving standard of care for repositioning. Resident 7 reviewed current turning/repositioning and hydration reviewed. Quarterly MDS and Care Plan were corrected on 7/19/15 to remove turning/repositioning program due to	

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F 278	Continued From page 7 Findings include: The Long-Term Care Facility RAI User's Manual, October 2014, stated the following: * Section M1200C (Turning/Repositioning Program), page M-38, stated, "The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g. [exampli gratia] reposition on side, pillows between knees) and frequency (e.g. every 2 hours). Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention." * Section M1200D (Nutrition or Hydration Intervention to Manage Skin Problems), pages M-38 and M-39, stated, "The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. . . . If it is determined that nutritional supplementation, i.e. adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and 'tailor nutritional supplementation . . . and obtain dietary consultation as needed,' . . ." * Section O0100 (Hospice), page O-4, stated, "Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. . . ."	F 278	resident is receiving standard of care for repositioning. MDS corrected for nutrition or hydration related to history of dehydration and weight loss rather than skin. Resident 10 MDS was corrected on 6/24/15 to include Hospice Resident 12 MDS corrected on 7/3/15 to remove turning/repositioning program due to resident is receiving standard of care for repositioning. Resident 13 MDS corrected on 6/26/15 to remove turning/repositioning program due to resident is receiving standard of care for repositioning. 2. All residents on Hospice, turning repositioning and hydration programs have the potential to be affected in this area. Resident's MDS and Care Plans will be reviewed as scheduled weekly and revised as needed to ensure accuracy of the MDS and comprehensive care plan. 3. Mandatory Nursing in-service on 7/23/15 to review the RAI manual M1200C turning and repositioning schedules, M1200D Nutrition and hydration, and O0100 hospice/end of life. 4. An audit will be developed ensure to compliance that MDS coding matches the care plan in turning/repositioning program, nutrition and hydration, and hospice/End of life services. The audit will be completed weekly for four weeks, monthly x2 and quarterly x 1 or as	

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F 278	Continued From page 8 Review of the medical record for Resident #1, #2, #7, #10, #12, and #13 occurred June 22-24, 2015. - Resident #13's quarterly MDS, dated 03/26/15, identified a turning/repositioning program present during the seven day assessment period. The current care plan stated, ". . . BED MOBILITY: Resident requires 1 staff participation to reposition and turn in bed." - Review of Resident #1's quarterly MDS, dated 04/07/15, identified a turning/repositioning program present during the seven day assessment period. The current care plan stated, "Focus: The Resident has h/o [history of] pressure ulcer to left/right buttocks, several excoriated areas to scrotum, and left thigh. . . 12/17/14 open area to coccyx. . . . Interventions/Tasks: . . . Assist to turn/reposition at least every 2-3 hours. Reposition with 2 people and lift sheet." - Review of Resident #2's quarterly MDS, dated 04/03/15, identified a turning/repositioning program present during the seven day assessment period. The current care plan stated, ". . . Turn and reposition in bed every 2 hours. . . ." - Review of Resident #12's medical record occurred on all days of survey. Resident #12's medical record occurred on all days of survey. Resident #12's quarterly MDS, dated 04/10/15, identified a turning/repositioning program present during the seven day assessment period. The current care plan stated, ". . . Remind/Assist to turn/reposition at least every 2-3 hours. . . ."	F 278	deemed necessary by QA committee. The DNS or designee is responsible for the completion of the audit. Results of the audit will be reported to the QA committee for further recommendations.	

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F 278	Continued From page 9 - Review of Resident #7's medical record occurred on all days of survey and identified a history of pressure ulcers. A quarterly MDS, dated 04/19/15, identified extensive assistance required with bed mobility, on a turning/repositioning program, and on nutrition or hydration interventions for skin problems. The current care plan stated, ". . . Focus: The resident has actual impairment to skin integrity R/T Fragile skin E/B skin tear. 4/8/15 abrasion/pressure area to (L) inner foot. 4/19/15 top of (R) foot. . . . Interventions/Tasks . . . Turn and reposition in bed. . . ." During an interview on 06/24/15 at 10:20 a.m., a managerial nurse (#4) stated the facility does not have an assessment to individualize turning/repositioning program. The CNA's are expected to turn/reposition residents every two hours. Resident #1, #2, #7, #12, and #13's medical records failed to identify a specific and individualized turning/repositioning program. - Resident #7's quarterly MDS, dated, 04/19/15, identified a nutrition or hydration program for skin problems. The current care plan stated, ". . . Focus: The resident has actual impairment to skin integrity R/T Fragile skin E/B skin tear. 4/8/15 abrasion/pressure area to (L) inner foot. 4/19/15 top of (R) foot. . . ." A progress note, dated 04/13/15, stated, "Weight 138# [pounds]. Significant weight loss. . . . Accepts high calorie cereal at breakfast. Offer chocolate milk with meals."	F 278		

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F 278	Continued From page 10 During an interview on 06/23/15 at 3:22 p.m., the dietician (#15) stated the nutritional interventions addressed Resident #7's weight loss and were not skin related. - Review of Resident #10's medical record occurred June 23-24, 2015. The current care plan stated, "Focus: The resident has an ADL [activities of daily living] self care performance deficit R/T [related to] Alzheimer's Disease EB [evidenced by] Impaired balance. 11/7/13 hospice care. . . ." The quarterly MDS, dated 06/15/15, failed to identify Resident #10 received hospice care.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		7/29/15

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F 279	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review and review of facility policy, the facility failed to develop a comprehensive care plan for 3 of 3 sampled residents (Resident #10, #13 and #14) that included measurable objectives and interventions to meet the resident's medical and nursing needs related to hospice services or end of life care. Failure to develop a comprehensive care plan based on resident specific needs does not allow staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "CARE PLAN" occurred on 06/24/15. This policy, dated 2012, stated, "POLICY: . . . Each resident will have an individualized comprehensive plan of care . . . This plan of care will be modified to reflect the care currently required/provided for the resident." - Review of Resident #13's medical record occurred on June 24, 2015. The quarterly MDS, dated 03/26/15, identified a Hospice program. The resident's current care plan failed to identify Hospice services or end of life care. - Review of Resident #10's medical record occurred on June 24, 2015. The current care plan stated, "Focus: The resident has an ADL [activities of daily living] self care performance deficit R/T [related to] Alzheimer's Disease EB [evidenced by] Impaired balance. 11/7/13 hospice care. . . ." The current care plan failed to identify a comprehensive end of life care plan.	F 279	End of Life Coding MDS 1. Resident 10 Care plan updated to include end of life care on 6/24/15 Resident 13 Care plan updated to include end of life care on 6/24/15 Resident 14 resident expired 6/7/15 2. All resident on hospice or end of life (comfort care) have the potential to be affected in this area. 3. A mandatory Nursing in-service will be held on 7-23-15 for end of life/Hospice MDS coding and Care planning 4. An audit will be developed to ensure compliance with coding MDS and Care Planning for residents on Hospice/end of life (comfort care). The audit will be completed weekly for four weeks, then monthly for x2 and then quarterly x3 or as deemed necessary by QA committee. The DNS or designee is responsible for the completion of the audit. Results of the audit will be reported to the QA committee for further recommendations.	

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	355095	A. BUILDING _____ B. WING _____	06/24/2015

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F 279	Continued From page 12 - Review of Resident #14's medical record occurred on June 24, 2015. A significant change MDS, dated 06/04/15, identified a Hospice program. The current care plan stated, "Focus: The resident has an ADL self care performance deficit R/T declining condition. 5/29/15 on hospice care. . . ." The current care plan failed to identify a comprehensive end of life care plan.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, resident interview, and staff	F 280	Care Plan	7/29/15

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F 280	Continued From page 13 interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' statuses for 5 of 13 sampled residents (Resident #5, #7, #8, #9, and #12). Failure to review and revise the care plan limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "CARE PLAN" occurred on 06/24/15. This policy, dated 2012, stated, "POLICY: . . . Each resident will have an individualized comprehensive plan of care . . . A qualified team or persons will review care plans at least quarterly. Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition . . . This plan of care will be modified to reflect the care currently required/provided for the resident." - Review of Resident #8's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 04/24/15, identified extensive assistance for eating, toilet use, and transfers. Resident #8's current care plan and Kardex report (utilized by certified nursing assistants) [CNAs] stated: * "EATING: Resident requires reminding, prompting, cueing with food and fluids assistance to eat as needed . . ." * "TOILET USE: Resident requires 1 staff participation to use toilet." * "TRANSFER: Resident uses sit to stand lift with 1 assist." Observation throughout the survey showed the following:	F 280	1. Resident 5 Care plan updated on 7/15/15 to remove foot rests/ foot board due to getting a new wheelchair in which resident is able to propel own wheelchair with feet. Care Plan ADLS focus was changed to include oral cares on 7/15/15 Resident 7 Care plan updated on 7/15/15 to include Resident toileting q shift and PRN Resident 8 expired on 6/29/15 Resident 9 Care Plan was updated on 7/15/15 to include the sit to stand for transfers Resident 12 Care Plan was updated 7/2/15 to show correct amount of assistance from staff with all transfers 2. All residents have the potential to be affected in this area. All care plans will be reviewed according to weekly Care Plan schedule for assistance with toileting and type of mechanical lift, oral cares, and wheelchair assistive devices. 3. A mandatory Nursing in-service will be held on 7-23-2015 on the need for a comprehensive accurate care plan with a focus, oral care strength, type of mechanical lift and amount of staff assistance needed, and wheelchair assistive devices such as foot boards or foot leg rests. 4. An audit will be developed to ensure compliance in the amount of staff assistance needed for toileting, type of mechanical lift to transfer a resident, oral care deficits and strength, and use of	

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F 280	Continued From page 14 * Resident #8 required staff assistance with food and fluid consumption. During an interview on 06/24/15 at 12:07 p.m., the CNA (#14) stated Resident #8 has needed total assistance with meals for "about the last couple of months." * Facility staff checked and changed Resident #8's incontinence brief in bed. * Facility staff utilized a full body mechanical lift to transfer Resident #8 from one surface to another. During an interview on 06/23/15 at 8:08 a.m., the CNA (#11) stated they (the CNAs) used to use a sit to stand lift to transfer Resident #8 but they have used a full body lift for a couple of months. - Review of Resident #9's medical record occurred on all days of survey. The quarterly MDS, dated 03/31/15, identified extensive assistance required for transfers and toilet use. Resident #9's current care plan and Kardex report stated: * "TRANSFERS: Resident requires 1 staff participation with transfers." * "TOILET USE: Resident requires 1 staff participation to use toilet." Observation throughout the survey showed facility staff utilized a sit to stand mechanical lift to transfer Resident #9 from one surface to another and two staff members assisted the resident to and from the bathroom. - Review of Resident #12's medical record occurred on June 23-24, 2015. The quarterly MDS, dated 04/10/15, identified extensive assistance of two or more persons for transfers and toilet use. Resident #12's current care plan and Kardex Report stated, "TRANSFER:	F 280	assistive devices such as foot boards and foot leg rests. The audit will be completed weekly for four weeks, then monthly for x2 and then quarterly x1 or as deemed necessary by QA committee. The DNS or designee is responsible for the completion of the audit. Results of the audit will be reported to the QA committee for further recommendations.	

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F 280	Continued From page 15 Resident required weight bearing support sit to stand lift and assist of 2 to transfer if resident able to participate. Transfer with total body lift and assist of 2 if resident is lethargic." Observation on 06/24/15 at 8:25 a.m. showed two CNAs (#14 and #26) transferred Resident #12 from the wheelchair to the toilet with a sit to stand mechanical lift. During interview at this time, the CNAs stated they use the Hoyer lift to transfer Resident #12 in and out of bed, and the sit to stand lift to transfer from wheelchair to toilet. The facility failed to ensure staff have clear direction on the plan of care regarding which type of mechanical lift staff should use to safely transfer the resident. - Review of Resident #7's medical record occurred on all days of survey. The quarterly MDS, dated 04/19/15, identified extensive assistance required for transfers and toilet use. The current care plan and Kardex report stated, "TRANSFER: Resident requires (1) staff participation with transfers, may use 2 assist as condition indicates or sit to stand lift prn [as needed]. . . . BRIEF USE: Resident uses incontinent products pullups continuously. Assist with changing incontinent product prn. . . . TOILET USE: Resident requires (1) staff participation to use toilet. 2 assist is used at times. . . ." Observation throughout the survey showed facility staff utilized a sit to stand lift to transfer Resident #7 from one surface to another. During interviews on 06/23/15 at 1:50 p.m., a CNA (#11) stated she last toileted the resident	F 280		

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F 280	Continued From page 16	F 280		

after lunch and a CNA (#17) stated she last toileted the resident before lunch. The care plan failed to direct how often facility staff should assist Resident #7 to the bathroom.

- Review of Resident #5's medical record occurred on all days of survey. Review of Resident #5's MDS, dated 05/28/15, identified the resident had moderate cognitive impairment, and total dependence on two or more staff for transfers.

The resident's current comprehensive care plan identified, ". . . The resident has an ADL self care performance deficit R/T cerebral palsy E/B Impaired balance, Limited mobility, Limited ROM [range of motion] to right arm/hand . . . AMBULATION: Resident is nonambulatory et [and] uses a wheelchair for locomotion with legrests [sic] et assist of 1. Pummel [sic] cushion, footboard, et back cushion in wheelchair. . . .ORAL CARE STRENGTH: Resident is able to rinse and spit, brush teeth after set up . . ."

Observation on 06/23/15 at 8:18 a.m. revealed Resident #5 self-propelled down a hallway in her wheelchair. The resident's wheelchair had no footboard or foot leg rests.

During an interview on 06/23/15 at 2:00 p.m., Resident #5 stated she bit into a hard carrot a few months ago and chipped a tooth. Resident #5 stated she went to the dentist for it, and now avoided some of the harder foods on the menu. Observation during the interview showed the resident had multiple missing teeth, darkened areas, and cracked/missing pieces of teeth. Observation also showed the resident had no

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F 280	Continued From page 17	F 280		

foot board applied to her wheelchair. The resident's feet touched the ground and moved back and forth as the resident self-propelled around the room.

On 06/23/15 at 4:25 p.m., a CNA (#9) stated the resident had missing teeth and broke a tooth over the winter from biting into a hard carrot.

On 06/24/15 at 11:50 a.m., a CNA (#11) stated the resident did not smile because she had missing teeth, and reported she thought the resident had several teeth pulled due to infection.

On 06/24/14 at 11:54 a.m., a CNA (#13) stated the resident chipped a tooth over the past winter when she bit into a hard carrot. The CNA (#13) also stated the resident identified being embarrassed of how her teeth looked, had a history of losing teeth, and currently had some "nubs" where parts of teeth had broken off.

On 06/24/15 at 11:55 a.m., a CNA (#10) stated she thought the resident used to have a foot board on her wheelchair but did not currently have one.

On 06/24/15 at 12:05 p.m., an administrative nurse (#3) stated the resident no longer had the foot board on her wheelchair, and the nurse (#3) planned to take it off the care plan at that time. The nurse (#3) also stated the resident had teeth pulled as they got bad, but did not remember seeing dark spots or broken teeth in the resident's mouth when she last assessed the resident's oral status.

The facility failed to revise the care plan to

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F 280	Continued From page 18 include the removal of Resident #5's wheelchair footboard, or to include her current dental issues.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: INSULIN ADMINISTRATION 1. Based on observation and review of manufacturer's instructions, the facility failed to properly administer medication during 2 of 2 observations of insulin pen administration (Resident #4 and #18). Failure of facility staff to follow the manufacturer's instructions of properly "priming" (a procedure to expel the air from the needle) the insulin pen (a small pen shaped device prefilled with insulin) prior to giving the injection has the potential for residents to receive the incorrect dose of insulin. Findings include: Review of the manufacturer's instructions for NovoLog FlexPen occurred on 06/24/15. This insert stated, ". . . Small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: . . . E. Turn the dose selector to select 2 units. F. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of cartridge. G. Keep the needle pointing up, press the button all the way. The	F 281	Part 1 Insulin administration 1. Resident 4 insulin pen received order on 7/15/15 to discontinue Flex pen when supply is complete and change to multi-dose vial. Resident 18 insulin pen received order on 7/14/15 to discontinue Flex pen when supply is complete and change to multi-dose vial. 2. All resident with dx diabetes and with order for insulin pens have the potential to be affected in this area. A list of residents with insulin pens will be generated and reviewed to ensure compliance. 3. A mandatory Nursing in-service will be held on 7/23/15 to review the instructions on how to prime an insulin pen. 4. An audit will be developed to ensure compliance with insulin pens and if the pen was primed. The audit will be completed weekly for four weeks, then monthly x2 and then quarterly x1 or as	8/6/15

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F 281	Continued From page 19 dose selector turns to zero. A drop of insulin should appear at the needle tip. If not, change the needle, and repeat the procedure. . . ." - On 06/22/15 at 4:24 p.m., observation showed a nurse (#18) prepared Resident #18's NovoLog FlexPen. The nurse attached a needle, dialed the dose to 59 units (58 units ordered), held the insulin device horizontally, and pushed the button to expel one unit. - On 06/22/15 at 4:38 p.m., observation showed a nurse (#18) prepared Resident #4's NovoLog FlexPen. The nurse attached a needle, dialed the dose to 11 units (10 units ordered), held the insulin device horizontally, and pushed the button to expel one unit. MEDICATION/TREATMENTS 2. Based on observation, record review, review of professional reference, and staff interview, the facility failed to follow professional standards of practice regarding medication/treatment administration for 4 of 13 sampled residents (Resident #3, #6, #9 and #13). Failure to follow standards of practice during medication/treatment administration may result in medications errors. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 864, stated, "Ten 'Rights' of Medication Administration . . . RIGHT DOCUMENTATION *Document medication	F 281	deemed necessary by QA committee. The DNS or designee is responsible for the completion of the audit. Results of the audit will be reported to the QA committee for further recommendations. Part II Medication/Treatment 1. Resident 3 nurse is doing the treatments in a timely manner charting completion after it is done. Resident 6 resident is receiving medications as ordered Resident 9 resident is receiving medications as ordered Resident 13 resident is receiving medications as ordered 2. All residents have the right to refuse medications/treatments. All refusals of medications or treatments will be documented in PCC EMR MAR or TAR. All residents have the potential to be affected with failure of medication documentation and/or documentation completed prior to med or treatment administration. 3. A mandatory nursing in-service was held on 7-23-15 to review with nurses and medication aides the right to refuse medication or treatments, the need to document the refusal in the PCC, EMR, MAR or TAR, and that no treatments can be documented prior to being administered. 4. An audit will be developed to ensure	

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F 281	Continued From page 20 administration after giving it, not before . . . *If a medication is not given, follow the agency's policy for documenting the reason why . . ." - Review of Resident #13's medical record occurred on 06/24/15. Review of the medication administration records (MARs) from March to June 2015 showed 12 occurrences when nursing staff failed to document the administration of medications and/or the resident's refusal of the medications. - Review of Resident #9's medical record occurred on all days of survey. Medications included Warfarin (a blood thinner) daily. Review of the December 2014 MAR showed nursing staff failed to document the administration and/or the refusal of Warfarin on 12/13/14. During an interview of the afternoon of 06/24/15, an administrative nurse (#4) stated nursing staff are expected to sign the MAR after the administration of a medication. If a resident refuses a medication, nursing staff are expected to document "refusal" on the MAR. - Review of Resident #6's medical record occurred on all days of the survey. Review of Resident #6's MAR for June 2015 showed a lack of documentation to indicate that the resident received Debrox Solution 6.5% ear drops, Methadone, and Aricept on 06/22/15 at 7:00 p.m. On 06/24/15 at 9:18 A.M., an administrative nurse (#4) reviewed the MAR and confirmed staff failed to document that the resident received his ordered medications. The nurse (#4) stated staff should initial the MAR when providing	F 281	compliance with documentation on the MAR/TAR when a resident refuses a medication or treatment and compliance with documenting all medications and treatments after they are administered. The audit will be completed weekly for four weeks, then monthly x2 and then quarterly x1 or as deemed necessary by QA committee. The DNS or designee is responsible for the completion of the audit. Results of the audit will be reported to the QA committee for further recommendations. Part III Dressing Change 1. Resident #3 dressing changes are being done according to Procedure and are following Professional Standards of Practice for Licensed Nurses. 2. All residents with physician orders for dressing changes have the potential to be affected if professional standards of practice are not followed. 3. A mandatory Nursing in-service was held 7-23-2015 to review Professional Standards of Practice and Protocol when performing resident dressing changes. 4. An audit has been developed to ensure compliance with Professional Standards of practice and protocol during resident dressing changes. The audit will be completed weekly for 4 weeks, then monthly x2, and then quarterly x1, or as deemed necessary by the QA committee.	

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F 281	Continued From page 21 medications to show that the resident received them. - Review of Resident #3's medical record occurred on all days of survey. Diagnosis included recent amputation of left second toe (06/10/15). Physicians orders stated to change the dressing daily with telfa and kling, one time a day to the left second toe amputation surgical site. Review of Resident #3's treatment record, on 06/23/15 at 9:30 a.m., showed the resident's dressing change as completed. During an interview shortly after this review, a licensed nurse (#22) confirmed she signed the dressing as completed, but had not yet done the dressing change. Resident #3's nursing progress note on 06/23/15 at 9:52 a.m. stated, "Both dressing to left foot and coccyx area was charted that was done but will be done after her bath." During an interview on 06/24/15 at 9:30 a.m. a nursing supervisor (#2) stated staff are expected to do a treatment and then sign it off as completed. DRESSING CHANGE 3. Based on observation, record review, review of facility procedure, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 sampled resident (Resident #3) observed during a dressing change. Failure to follow standards of practice during a dressing change may lead to infection of the wound and/or	F 281	The DNS or designee is responsible for the completion of the audit. Results of the audit will be reported to the QA committee for further recommendations.	

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F 281	Continued From page 22 spread of an infection. Findings include: Review of the facility policy titled "Wound Dressing Change" occurred on 06/24/15. This policy, revised 5/15, stated, " . . . Procedure: . . . 4. Put on gloves. . . .7. . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnosis included recent amputation of left second toe (06/10/15). Medications included Cipro 250 milligrams two times a day for infection of left foot. Physicians orders stated to change the dressing daily with telfa and kling one time a day for the toe amputation surgical site. Observation on 06/23/15 at 10:15 a.m. showed Resident #3 seated in the shower chair. The certified nursing assistant (CNA) (#19) removed Resident #3's dressing from her surgical wound on the left foot. The CNA failed to wear gloves and perform hand hygiene after removing the dressing. During an interview on 06/24/15 at 9:30 a.m. a nursing supervisor (#2) stated she expected a licensed nurse to remove the dressing from the surgical site, and wear gloves and perform hand hygiene after removing a dressing.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		7/29/15

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	355095	A. BUILDING _____ B. WING _____	06/24/2015

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

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F 309	Continued From page 23 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #3) with a physician order for non-weight bearing to the left foot. Failure to ensure Resident #3 remained non-weight bearing may contribute to increased pain and decreased healing of a surgical wound. Findings include: - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included diabetes with peripheral circulation disorder, recent amputation of left second toe (06/10/15) and a history of osteomyelitis. The current Minimum Data Set (MDS), dated 05/29/15, identified moderately impaired cognition and extensive assist of two or more staff with transfers. Resident #3's current care plan identified the following focus/interventions ". . . self care performance deficit R/T [related to] Musculoskeletal impairment . . . TRANSFER: Resident requires 2 staff participation with transfers. NWB LLE [non-weight bearing left lower extremity] . . ." Resident #3's current physicians orders stated the following: * Apply heel suspension boots when in bed * Change dressing daily with telfa and kling one	F 309	Part I non weight bearing status 1. Resident 3 transfer status has been changed to the use of a Total body mechanical lift and two staff assistance for transfer. No longer bears weight. Care plan updated 7/15/15 2. All residents with non-weight bearing physician orders have the potential to be affected in this area. This is the only resident currently with non-weight bearing orders. 3. Mandatory Nursing in-services will be held on 7-23-2015 to review the procedure titled "non-weight bearing for residents". 4. An audit will be developed to ensure compliance in non-weight bearing status. The audit will be completed weekly x4, then monthly x2 and then quarterlyx1 or as deemed necessary by QA committee. The DNS or designee is responsible for the completion of the audit. Results of the audit will be reported to the QA committee for further recommendations.	

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F 309	Continued From page 24 time a day to the surgical site * Non-weight bearing status of left foot * Use hoyer lift when transferring in and out of bed * Cipro (antibiotic) 250 milligrams (mg) two times a day for infection of left foot * Tylenol 650 mg four times a day * Tramadol (pain reliever) 50 mg one tablet four times a day for increased pain (started 06/20/15) Observation on 06/23/15 at 10:09 am showed two certified nursing assistants (CNAs) (#19 and #23) assisted Resident #3 out of the recliner into the wheelchair. Resident #3 had a green heel suspension boot on her left foot. During the transfer, Resident #3 bore weight on her left foot and while pivoting to the wheelchair, the boot slid forward on the floor. Observation on 06/23/15 at 10:15 a.m. showed a CNA (#19) assisted Resident #3 to a standing position in the bathing area. Resident #3 had a green heel suspension boot on her left foot. During the transfer the resident bore weight on her left foot while standing and holding onto the grab bar. Observation on 06/23/15 at 10:52 a.m. showed a CNA (#19) and a licensed nurse (#20) assisted Resident #3 from the bath chair to the wheelchair. Resident #3 had a green heel suspension boot on her left foot. During the transfer the resident bore weight on the left foot. During an interview on the morning of 06/23/15, a CNA (#19) stated Resident #3 can bear weight when wearing the green boot. (heel suspension boot)	F 309	Part II insulin administration 1. Resident 4 is receiving insulin according to procedure Resident 18 is receiving insulin according to procedure 2. All insulin dependent residents with diabetes that use novolog have the potential to be affected in this area. 3. Mandatory Nursing in-services will be held on 7-23-2015 to review the procedure titled, "hypoglycemic reaction" and the need to administer insulin and eat within 5-15 minutes after an insulin administration. 4. An audit will be developed to ensure compliance in timing of insulin administration and meal intake. The audit will be completed weekly for four weeks, then monthly x2 and then quarterly x1 or as deemed necessary by QA committee. The DNS or designee is responsible for the completion of the audit. Results of the audit will be reported to the QA committee for further recommendations. Part III Psychopharmacological medications 1. Resident 8 expired on 6/29/15 Resident 10 Care plan has been updated to allow staff to document Non Pharmacological interventions before giving PRN psychoactive medications.	

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F 309	Continued From page 25 During an interview on 06/24/15 at 10:47 a.m., an occupational therapy staff member (#25) stated, Resident #3 should wear the green suspension boot in bed and the blue (prevalon) boot when out of bed. She said allowing Resident #3 to stand and apply weight on her left foot while wearing the suspension boot is not following her NWB order. A physician assistant progress (PA) note from 06/23/15 stated the following: " . . . The patient's pain is under good control. She is on tramadol 50 mg q.i.d. [four times a day] alternating with Tylenol 650 mg q.i.d. . . . nursing staff state when they attempt to transfer her, she does have pain. . . . underlying incision does not appear healed at this point in time. . . ." During an interview on 06/24/15 at 11:57 a.m. a licensed nurse (#24) stated the physician assistant did a follow up with Resident #3 on 06/23/15. The PA did not remove the sutures as planned as the wound remained open and unhealed. During an interview on the morning of 06/24/15 a supervisory nurse (#2) stated she expected Resident #3 to wear the prevalon boot during transfers and while in the chair, and the heel suspension boot is not for transferring. The facility failed to follow the NWB status by allowing Resident #3 to bear weight to her left foot, and failed to follow the physician's order to wear the heel suspension boot only when in bed. This may have contributed to increased pain with transfers and decreased healing of the surgical	F 309	2. All residents with PRN psychoactive medications have the potential to be affected in this area. A list of residents that use PRN psychoactive medications will be generated and each will be reviewed. 3. Mandatory Nursing in-services will be held on 7-23-2015 to review the procedure titled "psychopharmacological medications" and the need to attempt non-pharmacological intervention prior to the administration of a PRN psychoactive medication. Nurse need to document in a progress note what intervention they tried prior to the administration on a prn psychoactive medication. 4. An audit will be developed to ensure compliance in the use of PRN psychoactive medications with a focus on the need to attempt and document at least 2 non-pharmacological intervention in a progress note prior to the administration of PRN psychoactive medications. The audit will be completed weekly for four weeks, then monthly x2 and then quarterly x1 or as deemed necessary by QA committee. The DNS or designee is responsible for the completion of the audit. Results of the audit will be reported to the QA committee for further recommendations.	

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F 309	Continued From page 26 site. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 11/12/14. INSULIN ADMINISTRATION 2. Based on observation and review of professional reference, the facility failed to ensure administration of insulin occurred within the ordered/recommended times for 1 of 2 sampled residents (Resident #4) and 1 of 1 supplemental resident (Resident #18) observed during insulin administration. Failure to provide nourishment within the specified time may result in low blood sugar levels (hypoglycemia). Findings include: "Nursing 2015 Drug Handbook," 35th edition, Wolters Kluwer, Philadelphia, pages 759-780, reviewed on 06/24/15, stated the following, ". . . Give NovoLog 5 to 10 minutes before start of meal. Give NovoLog Mix 70/30 up to 15 minutes before start of meal. . . ." - Observation of medication pass on 06/22/15 at 4:24 p.m. showed a nurse (#18) administered 58 units of NovoLog Mix 70/30 insulin to Resident #18. The resident received chocolate milk at 5:15 p.m. (51 minutes after the insulin administration). - Observation of medication pass on 06/22/15 at 4:38 p.m. showed a nurse (#18) administered 10 units of NovoLog insulin to Resident #4. The resident received chocolate milk at 5:20 p.m. (42 minutes after the insulin administration). Facility staff failed to ensure Resident #4 and #18	F 309		

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received a nourishment (carbohydrate) or meal within the specified time. This practice may negatively impact all insulin diabetic residents residing at the facility.

PSYCHOPHARMACOLOGICAL MEDICATIONS

3. Based on record review and review of facility policy, the facility failed to provide the necessary care and services to manage behavioral and psychological symptoms of dementia (BPSD) for 2 of 3 sampled residents (Resident #8 and #10) identified with behaviors and receiving as needed (PRN) psychotropic medications. Failure to thoroughly assess the residents' behaviors, implement individualized interventions, including non-pharmacological interventions, and establish on-going monitoring of the behaviors may result in decreased physical, mental, and psychosocial well-being and may negatively impact the residents' quality of life.

Findings include:

Review of the facility policy titled "PSYCHOPHARMACOLOGICAL MEDICATIONS AND SEDATIVE/HYPNOTICS" occurred on 06/24/15. This policy, revised in March 2015, stated, "PROCEDURE: Non-Emergency Administration: 1. Before administration of non-emergency psychopharmacological . . . the following must be competed: a. Documentation in PCC-POC [computer documentation] observations of mood symptoms or behaviors that cause the resident distress and/or endanger the resident or others and response to interventions used. . . . 7. While the use of prn psychopharmacological medications . . . is not

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encouraged, if a prn physician's order is received, ensure that the order has clear parameters, i.e., severe agitation that does not respond to other care plan interventions. It is important to initiate other care plan interventions prior to the use of prn psychopharmacological medications . . ."

- Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia and anxiety. Medications included Zoloft (antidepressant) daily and Haldol (antipsychotic) 0.5 milligrams (mg) PRN.

Resident #8's quarterly Minimum Data Set (MDS), dated 04/24/15, identified severe cognitive impairment and physical and verbal behaviors occurred one to three days during the assessment period. The current care plan and Kardex identified the following mood/behavior interventions: one to one visits, music, encourage to attend activities and non-physical activities, encourage to be out of room/at an activity/at nurses station, rest periods, devotions, church services, fancy fingers, offer snack/drink, offer assistance to call family, remind to ask for help/use call light, and assist in finding TV/music programs to listen to.

Review of the medication administration records (MARs) from April 2015 through June 23, 2015 showed Resident #8 received PRN Haldol seven times in April, 25 times in May, and 13 times in June. Nursing staff documented the non-pharmacological interventions attempted six out of 45 times.

- Review of Resident #10's medical record

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F 309	Continued From page 29 occurred on June 24, 2015. Diagnoses included dementia, Alzheimer's disease, and anxiety. Medications included Ativan (antianxiety) 0.5 mg PRN. Resident #10's quarterly MDS, dated 06/15/15, identified severe cognitive impairment and other behaviors occurred daily during the assessment period. The current care plan and Kardex identified the following mood/behavior interventions: one to one visits, activities, music, outdoor walks, offer snack, offer pastor visits, rest periods, give her cards or a photo album, and reminisce. Review of the MARs from April 2015 through June 23, 2015 showed Resident #10 received PRN Ativan three times. Nursing staff failed to document the non-pharmacological interventions attempted two out of the three times. Failure to assess the reason/causative factor(s) for behaviors including identifying precipitating factors, and implement appropriate non-pharmacological interventions and establish accurate on-going monitoring may have resulted in the inappropriate utilization of anti-psychotic medication.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		7/29/15

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F 312	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure residents received the necessary services to maintain good nutrition for 1 of 1 sampled resident (Resident #8) who required extensive assistance with meals and 1 of 1 sampled resident (#2) who required extensive assistance with toilet use/personal hygiene and care planned to be checked for toileting every 2 hours. Failure to provide assistance during meals placed Resident #8 at risk for weight loss and failure to check and toilet Resident #2 placed the resident at risk for skin breakdown. Findings include: - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia and anxiety. The quarterly Minimum Data Set (MDS), dated 04/24/15 identified extensive assistance required for eating. Resident #8's current care plan stated, "EATING: Resident requires reminding, prompting, cueing with food and fluids assistance to eat as needed. Rsdt [resident] moved to assist room." Observation on 06/23/15 at 7:45 a.m. showed Resident #8 seated at a table for residents who require assistance with meals. The meal included prunes, diced fruit, prune juice, apple juice, water, and hot tea. Observation showed the resident reached for but could not obtain a food or fluid item on the table. An unidentified certified nursing assistant (CNA) stated, "Whatcha [what do you] need [Resident name]?" The CNA failed	F 312	Toileting Program 1. Resident 8 expired on 6-29-15. Resident 2 care plan was updated under ADL focus care plan for toileting: Wears pull ups. The routine daily practice of every two hours was removed on 7-14-15 and resident Care Plan on 7/9/15 was updated to assistance resident with meal intake. 2. All residents that require extensive assistance with toilet use/personal hygiene and are care planned for toileting and dining needs have the potential to be affected in this area. 3. Mandatory Nursing In-service will be held on 7-23-2015 to review the procedures titled ¿Toileting Programs¿ and ¿Dining Assistance.¿ Routine daily practices will be reviewed with a focus on the need to prevent weight loss and skin break down with adequate meal assistance, and the need for an individualized care planned toileting schedule. Routine standards of practice for toileting every 2 hours will not be listed on the care plan. 4. An audit will be developed to ensure compliance in the prevention of weight loss and skin breakdown. Residents with weight loss and skin breakdown will have their care plan reviewed. The audit will be completed weekly for four weeks, then	

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F 312	Continued From page 31 to assist or offer any food or fluids to the resident. At 7:55 a.m., the CNA stated to another CNA seated at the table, "She's [Resident #8] not going to eat anything," and removed her from the table. Resident #8 consumed no food or fluids. Observation on 06/23/15 at 11:40 a.m. showed Resident #8 seated at the same table as above. The meal included noodles, fish, a bun, water, and hot tea. A CNA (#16) sat next to the resident and stated, "Do you want to try something [resident's name]? . . . Wanna [want to] try some ice cream or pancakes? . . . Not feeling well? . . . Do you want to go back to the nurse's station?" The CNA (#16) then stated to another CNA seated at the table, "She doesn't want to eat anything." The CNA (#16) failed to offer or assist the resident with her food including to wait for a reply from the resident before asking another question. During an interview on 06/24/15 at 12:07 p.m., the CNA (#14) stated Resident #8 has not been able to feed herself for the past couple of months and has required total assistance from staff. - Review of Resident #2's medical record occurred on all days of survey. Medical diagnoses included history of pressure ulcer to buttocks and history of urinary tract infection. The quarterly MDS, dated 04/03/15, identified Resident #2 required extensive assist with transfers, toilet use, and personal hygiene, frequently incontinent of urine, occasionally incontinent of bowel, and severely impaired cognition in making daily decisions. Resident #2's current care plan stated, "Focus:	F 312	monthly x2 and then quarterly x1 or as deemed necessary by QA committee. The DNS or designee is responsible for the completion of the audit. Results of the audit will be reported to the QA committee for further recommendations.	

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F 312	Continued From page 32 The resident has bladder incontinence R/T [related to] dementia and impaired mobility E/B [evidenced by] needs assist with toileting . . . Interventions/Tasks: . . . Brief use: Resident uses pull-up during day/brief at night. Bathroom with cares, before meals and per resident request. . . The resident has h/o [history of] bowel incontinence R/T confusion . . . Check resident every two hours and assist with toileting as needed. . . . Kardex Report: Bladder/Bowel/Toileting: Bathroom with cares before meals and per resident request. . . . Check and change during rounds at night as needed. Check resident every two hours and assist with toileting as needed. . . ." Observation on 06/23/15 at 8:45 a.m. showed two CNAs (#5 and #6) toileted Resident #2 in the bathroom. Observation at 11:10 a.m. showed staff (CNA #5 and CNA #6) transferred resident from the recliner in the lounge to her wheelchair and then wheeled her to the activity room. Observation at 11:45 showed staff wheeled resident to the dining room for lunch. Facility staff failed to check Resident #2 for incontinence every two hours and toilet her before lunch as per care plan. Observation showed staff toileted Resident #2 at 1:00 p.m. Resident #2 voided on the toilet and was incontinent of bowel in her brief. Review of the "Toilet Use" form, dated 06/23/15, identified staff failed to toilet Resident #2 during the period listed above. During interview the afternoon of 06/24/15, an administrative nurse (2) confirmed staff failed to check Resident #2 every two hours and toilet as needed.	F 312		
F 314	483.25(c) TREATMENT/SVCS TO	F 314		7/29/15

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F 314 SS=D	Continued From page 33 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 11/12/14. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment and services to promote the healing of a pressure ulcer for 2 of 2 sampled residents (Resident #1 and #3) with a pressure ulcer. Failure to implement established treatment and interventions has the potential to delay the healing of a pressure ulcer. Findings include: Review of the facility policy titled "Pressure Ulcers" occurred on 06/24/15. This policy, dated 09/2012, stated, "Purpose: To provide appropriate assessment and prevention of pressure ulcers as well as treatment when necessary. Policy: . . . A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing . . ."	F 314	Pressure Ulcer Prevention 1. Resident 1 expired on 7-12-2015. Resident 3 dressing is being done by nurse according to physician orders 2. All residents with current pressure ulcers have the potential to be affected in this area. A list of residents with pressure ulcers will be generated from PCC and monitored for compliance. 3. Mandatory Nursing in-service will be held on 7-23-2015 to review the procedure titled for "Pressure Ulcer Prevention". 4. An audit will be developed to ensure compliance in pressure ulcer treatment and management. Monitor if the daily dressing change is done by the nurse and a new dressing applied in a timely manner. The audit will be completed	

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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 - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included a pressure ulcer to the coccyx. The current care plan stated, "Focus: The resident has pressure ulcer to coccyx . . . Interventions: . . . treatment per MD (medical doctor) orders. . . ." Physician orders stated, "Medihoney Wound/Burn Dressing Gel (Wound Dressings) Apply to coccyx topically one time a day for open wound . . ." A "Wound Data Collection" form dated 06/23/15, identified a 1.7 by 0.6 by 0.5 centimeters (cm) open area to the coccyx. Observation on 06/23/15 at 10:15 a.m. showed a certified nursing assistant (CNA) (#19) assisted Resident #3 to a standing position in the bathing area. Observation of the coccyx area identified an open area with no dressing. The CNA (#19) stated the nurse removed the dressing. During an interview on 06/23/15, after the bath, a licensed nurse (#22) stated she did not remove Resident #3's coccyx dressing. A CNA (#23) stated she removed the coccyx dressing around 7:00 a.m. due to it being soiled. Staff failed to re-apply a coccyx dressing to Resident #3's pressure ulcer leaving the ulcer area uncovered for over 3 hours. During an interview on 06/24/15 at 9:30 a.m. a nursing supervisor (#2) stated she expected staff to apply a new dressing to the coccyx. - Review of Resident #1's medical record occurred on all days of survey. Medical diagnoses included chronic ulcers, muscle	F 314	weekly for four weeks, then monthly for x2 and then quarterly x1 or as deemed necessary by QA committee. The DNS or designee is responsible for the completion of the audit. Results of the audit will be reported to the QA committee for further recommendations.	

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F 314	Continued From page 35	F 314		

weakness, colostomy, suprapubic catheter, and edema. The quarterly Minimum Data Set (MDS), dated 04/07/15, identified Resident #1 required extensive assist of two or more persons for bed mobility, locomotion on and off unit, dressing, personal hygiene, and total assistance of two or more persons for transfers and toilet use. Resident #1's current care plan states, "The resident has actual impairment to skin integrity R/T [related to] abrasions to RLE [right lower extremity] and left gluteal fold . . . The resident has h/o pressure ulcer to left/right buttock, several excoriated areas to scrotum, and left thigh. 12/17/14 open area to coccyx. . . . Interventions/Tasks: Assist to turn/reposition at least every 2-3 hours. Reposition with 2 people and lift sheet. . . . Provide air mattress relieving/reducing pressure device on bed, foam/gel cushion in W/C [wheel chair]. . ."

Observation on 06/23/15 showed Resident #1 in his wheelchair from 7:45 a.m. to 12:00 noon. During interview at 1:45 p.m. on 06/23/15, a CNA (#6) stated Resident #1 had been in his wheelchair from 5:30 a.m. in the morning until 12:45 p.m. when staff transferred him to his bed. The CNA stated Resident #1's routine is to be in his wheelchair from early morning until after lunch, when staff transfer him from the wheelchair to his bed.

Review of Resident #1's turning/repositioning log from 06/23/15 showed staff had repositioned Resident #1 at 6:05 a.m. and not again until 1:25 p.m., a span of 7 hours, 20 minutes. The documentation also showed staff repositioned Resident #1 at 1:25 p.m. and not again until 7:39 p.m., a span of approximately 6 hours.

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F 314	Continued From page 36 Failure to reposition Resident #1 every 2-3 hours as care planned while in his wheelchair places the resident at risk for impaired healing of current pressure ulcers and at risk for new pressure areas to develop.	F 314		
F 323 SS=D	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: Based on observation, staff interview, record review, and policy review, the facility failed to appropriately utilize assistive devices to prevent accidents for 2 of 12 sampled residents (#3 and #5) observed transferred/repositioned with assistance from staff. Failure to use appropriate assistive devices during transfers and repositioning placed the residents at risk for an accident or injury. Findings include: Review of the facility policy titled "Gait (Transfer) Belt" occurred on 06/24/15. This policy, dated 10/2013, stated, "Purpose: To safely transfer or ambulate resident, To aid resident in maintaining balance, To avoid injury to both resident and staff member . . . Procedure: . . . 2. Place belt around	F 323	Repositioning 1. Resident 3 is non-weight bearing with the use of full body lift and the care plan updated on 7/21/2015. Resident 5 is being transferred with full body lift and 2 assist care and the plan updated 7/15/15. 2. All resident that need staff assistance with transfer or use a mechanical lift have the potential to be affected in this area. A list of residents will be generated to ensure compliance in transfer assistance. 3. Mandatory Nursing in-services will be held on 7-23-2015 to review the procedures titled "transfer belt" with a	7/29/15

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F 323	Continued From page 37 resident's waist over clothing. If over bare skin, place a towel under the gait belt. . . . 7. Do not use the pants/slack belt as a gait (transfer) belt. . . ." - Review of Resident #5's medical record occurred on all days of survey. Resident #5's quarterly Minimum Data Set (MDS), dated 05/28/15, identified the resident with moderate cognitive impairment, and totally dependent on two or more staff for transfers. Observation on 06/23/15 at 10:22 a.m., showed certified nurse aides (CNAs) (#17 and #11) assisted Resident #5 to her wheelchair using a full-body lift. After removing the sling, one staff member grabbed under the right axilla and knee, the other staff member grabbed under the left axilla and knee, and the two staff members lifted the resident to reposition her higher in the wheelchair. On 06/23/15 at 4:18 p.m., observation showed two CNAs (#7 and #8) assisted Resident #5 to her wheelchair from the bed using a full-body lift. After the CNAs sat the resident in the wheelchair and removed her sling, one CNA grabbed under the resident's arms by the axilla and the other grabbed at the knees, and lifted the resident to reposition her higher in the chair. The resident grimaced as the staff members lifted upward and repositioned her. During an interview on 06/24/15 at 12:00 p.m., an administrative nurse (#3) stated the facility had a safe handling program to prevent staff from having to physically lift the residents. The nurse (#3) stated staff should have applied a sling and	F 323	focus on the need to use a full body lift to reposition manually. 4. An audit will be developed to ensure compliance in the proper use of transfer devices. Audit will be done on random residents that require assistance with transfers. The audit will be completed weekly for four weeks, then monthly for x2 and then quarterly x 1 or as deemed necessary by QA committee. The DNS or designee is responsible for the completion of the audit. Results of the audit will be reported to the QA committee for further recommendations.	

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F 323	Continued From page 38 used the full-body lift to reposition the resident in the wheelchair. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included recent amputation of left second toe (06/10/15) and history of osteomyelitis. The current MDS, dated 05/19/15, identified moderately impaired cognition and extensive assist of two or more staff with transfers. Resident #3's current care plan identified the following focus/interventions ". . . self care performance deficit R/T Musculoskeletal impairment . . . TRANSFER: Resident requires 2 staff participation with transfers. . . ." Observation on 06/23/15 at 10:15 a.m. showed a CNA (#19) assisted Resident #3 to a standing position in the bathing area. The CNA (#19) pulled on the back of the resident's pants to assist the resident to stand. The CNA failed to use a gait belt and assistance of two staff to transfer Resident #3 to the bath chair. Observation on 06/23/15 at 10:52 a.m. showed a CNA (#19) and a licensed nurse (#20) assisted Resident #3 from the bath chair to the wheelchair. The nurse and the CNA lifted under Resident #13's axilla to assist the resident out of the bath chair. Staff failed to use a gait belt to assist the resident.	F 323		
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	F 441		8/6/15

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F 441	Continued From page 39 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 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: THIS IS A REPEAT DEFICIENCY FROM THE	F 441	Part I Glucometer disinfecting	

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F 441	Continued From page 40 SURVEY COMPLETED ON 11/12/14. 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 4 of 9 sampled residents (Resident #2, #3, #8, and #9) observed during cares. Failure to follow infection control practices during personal cares (Resident #2, #3, #8, and #9) and during dressing changes (Resident #3) has the potential to cause or spread infection within the facility. Findings include: Review of the facility policy titled "HAND HYGIENE AND HANDWASHING" occurred on 06/24/15. This policy, revised in June 2014, stated, ". . . Wash hands with plain soap and water or with anti-microbial soap and water: *If hands are visibly soiled (dirty) *If hands are visibly contaminated with blood or body fluids . . . If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning your hands: *Before having direct contact with residents *After having direct contact with a resident's skin *After having contact with body fluids, wounds or broken skin *After touching equipment or furniture near the resident *After removing gloves . . ." Review of the facility policy titled "WOUND DRESSING CHANGE" occurred on 06/24/15. This policy, revised May 2015, stated, ". . . PROCEDURE: . . . 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	F 441	1. Resident 4 has Accucheck's done with disinfected glucometer machines. No negative affect occurred from this practice. 2. All residents with physician orders for blood glucose monitoring have the potential to be affected in this area. 3. Mandatory Nursing in-services will be held on 7-23-2015 to review the procedures titled "Cleaning and Disinfecting blood glucose meters" with a focus on the need to disinfect the machine between each resident. 4. An audit will be developed to ensure compliance in cleaning glucometers ensuring machines are disinfected with a disposable germicidal wipe after each blood glucose check. The audit will be completed weekly for four weeks, then monthly x2 and then quarterly x 1 or as deemed necessary by QA committee. The DNS or designee is responsible for the completion of the audit. Results of the audit will be reported to the QA committee for further recommendations. Part II Personal hygiene and Dressing care 1. Resident 2 is receiving hygiene per staff procedure Resident 3 is receiving hygiene per staff procedure. Staff providing resident cares are wearing gloves and using proper	

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F 441	Continued From page 41 same plastic bag. Perform hand hygiene. . . ." Review of the facility policy titled "CATHETERIZATION" occurred on 06/24/15. This policy, revised in 2009, stated, "POLICY: . . . Catheters will always be properly secured, . . . Catheter tubing should never be allowed to touch the floor. . . ." - Observation on 06/23/15 at 10:00 a.m. showed Resident #8 lying on her bed. Two CNAs (#11 and #17) entered the room, applied gloves, and checked the resident's brief (dry). The CNAs removed their gloves and transferred Resident #8 from bed to a wheelchair. The CNA (#17) combed the resident's hair, applied some makeup, offered fluids, and exited the room. The CNA (#17) failed to perform hand hygiene after removing her gloves and before completing other tasks, and before exiting the room. - Observation on 06/23/15 at 10:20 a.m. showed Resident #9 seated on the toilet. The CNA (#11) applied gloves, provided perineal cares, after Resident #9 had a bowel movement and removed her gloves. Two CNAs (#10 and #11) utilized the sit to stand lift and transferred the resident to a recliner. The CNA (#11) removed the lift harness, operated the remote for the recliner, opened the curtains, and then washed her hands. The CNA (#11) failed to perform hand hygiene after providing perineal cares and removing her gloves. - Observation on 06/23/15 at 8:45 a.m., showed two certified nursing assistants (CNAs) (#5 and #6) assisted Resident #2 with toileting in the bathroom. The CNA (#6) provided perineal care	F 441	hand washing techniques. Only LNs are changing resident's dressings and are following proper hygiene procedures. Resident 8 expired on 6-29-15. Resident 10 is receiving hygiene per staff procedure. 2. Residents that require assistance with personal hygiene and dressing changes have the potential to be affected in this area. The list of residents will be generated from PCC reports and will be used for auditing. 3. A mandatory nursing in-service was held 7-23-2015 to review procedures titled hand hygiene and hand washing with a focus on the need to wash hands after the gloves have become soiled, to remove gloves after hygiene cares and dressing changes, then wash hands and reapply new gloves to finish resident cares, and then wash hands again prior to leaving the room. 4. An audit has been developed to ensure compliance in the proper use with hand hygiene and hand washing before and after personal cares and dressing changes are completed and hands are washed prior to leaving the resident's room. The audit will be completed weekly for four weeks, then monthly x2 and then quarterly x1 or as deemed necessary by QA committee. The DNS or designee is responsible for the completion of the audit. Results of the audit will be reported to the QA committee for further	

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F 441	Continued From page 42 after Resident #2 had a bowel movement. Without removing her gloves and performing hand hygiene, the CNA (#6) assisted with transferring Resident #2 via the sit-to-stand lift (a mechanical lift) from the bathroom to the resident's wheelchair. The CNA (#6) removed Resident #2's transfer sling, applied foot pedals to the wheelchair, positioned the resident in the chair, and straightened the resident's clothing. The CNA then removed her gloves and washed hands. The CNA failed to remove her gloves and perform hand hygiene after providing pericares for Resident #2. Observation on 06/23/15 at 1:00 p.m., showed two CNA's (#5 and #6) assisted Resident #2 with toileting. The CNA (#6) provided perineal care after Resident #2 had a bowel movement. The CNA (#6) removed her gloves, and then assisted with transferring Resident #2 via the sit-to-stand lift to the resident's bed. The CNA (#6) repositioned the resident in bed, placed a hot pack on the resident's left hip, covered the resident with a blanket, placed the resident's call light in reach, and wheeled the mechical lift outside of the room. The CNA then washed her hands with soap and water in the bathroom. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included recent amputation of left second toe (06/10/15). Medications included Cipro (antibiotic) 250 milligrams two times a day for infection of left foot. Physicians orders stated to change the dressing daily with telfa and kling. Observation on 06/23/15 at 10:15 a.m. showed Resident #3 seated in the shower chair. The CNA	F 441	recommendations. Catheterization part III 1. Resident #3 staff has been educated to never let the catheter bag touch the floor. 2. All resident with indwelling Foley catheters have the potential to be affected in this area. A list of resident's will be generated from PCC reports and will be used for auditing. 3. Mandatory Nursing in-services will be held on 7-23-2015 to review the procedures titled "catheterization" with a focus on the need to keep the collection bag from touching the floor. 4. An audit will be developed to ensure compliance through staff observation and interview to ensure urine collection bag doesn't touch the floor. The audit will be completed weekly for four weeks, then monthly x2 and then quarterly x1 or as deemed necessary by QA committee. The DNS or designee is responsible for the completion of the audit. Results of the audit will be reported to the QA committee for further recommendations.	

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F 441	Continued From page 43 (#19) removed Resident #3's dressing from her surgical wound on the left foot. The CNA (#19) placed a plastic bag over Resident #3's foot and secured the bag with tape. The CNA failed to wear gloves and perform hand hygiene after removing the dressing. During the above observation the CNA (#19) placed Resident #3's foley catheter bag on the shower room floor. During an interview on 06/24/15 at 9:30 a.m. a nursing supervisor (#2) stated she expected a licensed nurse to remove the dressing from the surgical site, and wear gloves and perform hand hygiene after removing a dressing. This nurse also stated staff are expected to not place the foley catheter bag on the floor. GLUCOMETER DISINFECTING 2. Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed infection control practices for 1 of 1 sampled resident (#4) observed receiving a blood glucose check. Failure to disinfect the glucometer after each resident use has the potential to spread infection to residents and staff. Findings include: Review of the facility policy titled, "CLEANING AND DISINFECTING BLOOD GLUCOSE METERS" occurred on 06/24/15. This policy, revised 11/14, stated, ". . . Disinfecting: 1. To disinfect the meter, dilute 1 ml [milliliter] of house bleach in 9 ml of water to achieve a 1:10 dilution.	F 441		

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F 441	Continued From page 44 2. Dampen a paper towel and thoroughly wipe down the meter. NOTE: If a bleach solution is not used, it is also acceptable to use Steris Coverage Spray . . . or Sani-Cloth Germicidal Disposable Wipe. . . ." Observation of medication administration occurred on 06/22/15 at 4:38 p.m. After the nurse (#18) checked Resident #4's blood glucose level, she cleansed the glucometer with an alcohol wipe and stated, "I don't know what I'm suppose to use to wipe it off." During an interview on 06/22/15 at 4:57 p.m., an administrative nurse (#1) stated staff should use germicidal wipes and not alcohol wipes.	F 441		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the	F 520		7/29/15

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F 520	Continued From page 45 requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the North Dakota Department of Health, Division of Health Facilities provider files and record review, the facility failed to maintain a Quality Assurance (QA) process which identified and addressed quality issues; and failed to develop and implement appropriate plans of action to correct deficient practice and ensure compliance with federal requirements. Findings include: Refer to F225, F309, F314, and F441 for specific findings. These four citations are repeat deficiencies. Failure to effectively utilize QA resulted in the facility not maintaining compliance in the following: *F225 - reporting/investigating injuries of unknown origin *F309 - administration of insulin 42 and 51 minutes before a meal *F314 - treatment and prevention of pressure ulcers *F441 - infection control practices regarding hand hygiene, glove use, and a foley catheter bag	F 520	QA Committee 1. QA committee will meet on 7/20/15 to address current repeat F tags from 2014 inspection of F 225, F 309, F 314, and F 441. All survey tags were discussed and plan of correction started for the process of improvement. 2. All residents have the potential to be affected in this area. 3. A mandatory Nursing in-service will be held on 7-23-2015 to review the procedure from the repeat deficiencies in F 225,F 309, F 314, and F 441 (see above) QA and committee will develop and implement appropriate plans of action (focus groups) to identify and correct quality deficiencies including monitoring the effects of implemented changes and making needed revisions to the action plans. 4. Monitoring: results of audits will be taken to the QA committee for root cause analysis for further monitoring and modification to sustain compliance. The administrator will complete quality audit	

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 _____	06/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 46	F 520	committee minutes x12 months	