STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 01/19/16 and completed on 01/21/16, the sample included 2 residents for complete review, 8 residents for focused review, and 1 closed record for review. The sample included 6 additional residents to verify specific concerns during the survey.	F 000		
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. 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.	F 278		2/25/16

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

Electronically Signed | 02/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 1 This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 1 of 2 sampled resident (Resident #5) and 4 supplemental residents (Resident #12, #14, #15, and #16). Failure to complete the correct MDSs after being discharged from the facility with return anticipated may result in the inaccuracy of the facility's Resident Level Quality Measure Reports. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2015, on page 2-8 stated, ". . . Admission refers to the date a person enters the facility and is admitted as a resident. A day begins at 12:00 a.m. and ends at 11:59 p.m. . . . this date is considered the 1st day of admission. Completion of an OBRA (Omnibus Budget Reconciliation Act) Admission assessment must occur in any of the following admission situations: * when the resident has never been admitted to this facility before; OR * when the resident has been in this facility previously and was discharged return not anticipated; OR * when the resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge . . . "	F 278	A call was made to the State RAI Coordinator for North Dakota to assist us with making the following corrections on the MDS's cited: 1. With Resident #5, we are to continue with our current MDS schedule and no specific correction was made except to be noted by the State RAI Coordinator. 2. With Resident #12, we set an ARD date for 1/31/16 and will complete a new annual assessment. 3. With Resident #14, we set an ARD date for 2/7/16 and will complete a new annual assessment. 4. With Resident #15, we are to continue with our current MDS schedule for her and no specific correction was made except to be noted by the State RAI Coordinator. 5. With Resident #16, we are to continue with our current MDS schedule for her and no specific changes were made except to be noted by the State RAI Coordinator. The MDS Coordinator reviewed all current residents who were discharged in the past year and there were found to be no other MDS deficits regarding discharged residents with return anticipated. An email was sent to the State RAI Coordinator indicating this. Education was provided to the current	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 2 - Review of Resident #5's medical record occurred on all days of survey. Resident #5's record identified a hospital stay from September 03-09, 2015. The facility completed a discharge assessment return anticipated MDS and upon return from the hospital, incorrectly completed an admission MDS. - Review of Resident #12's medical record occurred on January 20-21, 2016. Resident #12's record identified a hospital stay from October 31 to November 02, 2015. The facility completed a discharge assessment return anticipated MDS and upon return from the hospital, incorrectly completed an admission MDS. - Review of Resident #14's medical record occurred on January 20-21, 2016. Resident #14's record identified a hospital stay from November 10-11, 2015. The facility completed a discharge assessment return anticipated MDS and upon return from the hospital, incorrectly completed an admission MDS. - Review of Resident #15's medical record occurred on January 20-21, 2016. Resident #15's record identified a hospital stay from December 18, 2015 to January 05, 2016. The facility completed a discharge assessment return anticipated MDS and upon return from the hospital, incorrectly completed an admission MDS. - Review of Resident #16's medical record occurred on January 20-21, 2016. Resident #16's record identified a hospital stay from June 01-04, 2015. The facility completed a discharge assessment return anticipated MDS and upon	F 278	MDS Coordinator on the proper procedure by reviewing our current policies and the RAI manual. In addition a discussion was held with the State RAI Coordinator for clarification. The Director of Nursing or designee will audit all resident discharges on the MDS for accuracy monthly for the first quarter to assure continued compliance and then quarterly for the first year and then as needed. These audits will be reported to the QA committee for review and changes will be made as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 3 return from the hospital, incorrectly completed an admission MDS.	F 278		
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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 12/18/14, 01/23/14, 01/16/13, and 02/02/12. Based on observation, record review, and review of facility policy, the facility failed to review and revise care plans to reflect the residents' current status for 4 of 10 sampled residents (Resident #1, #2, #4, and #5). Failure to ensure care plans	F 280	The corrective actions taken to assist residents affected by this practice will be as follows: 1.Resident #1's care plan was reviewed and updated to reflect the following: A. Resident #1's current pressure ulcer to the right heel and the abrasion/sore to the top of right foot.	2/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 280	Continued From page 4 reflected the residents' current status and needs limited staff's ability to ensure consistency and continuity of care. Findings include: Review of the facility policy "Care Plan" occurred on 01/21/16. This document, dated September 2012, stated "POLICY . . . Each resident will have an individualized comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. . . . 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 #1's medical record occurred on all days of survey and identified a pressure ulcer to the right heel on 11/18/15 and an abrasion/sore to the top of the right foot and right second toe. Observations on all days of survey showed Resident #1 wearing pressure relieving boots on both feet and a pillow under the right foot to float the heel while in bed. Resident #1's current care plan for skin, revised on 07/14/15, identified ". . . potential impairment to skin integrity R/T [related to] DM [diabetes mellitus], Diabetic peripheral neuropathy, peripheral vascular disease . . . past hx [history] of pressure ulcers per family. . . ." Facility staff failed to identify on the care plan the current pressure ulcers and impaired skin integrity, and	F 280	B. Resident #1's current use of pressure relieving devices. C. Resident #1's current use of personal tab alarm to wheelchair and bed. 2. Resident #4's care plan was updated to show the pressure ulcer was healed. Since this update Resident #4 has expired. 3. Resident #2's care plan was updated to reflect his pressure ulcer on his coccyx. Since the survey, this resident has expired. 4. Resident #5's care plan was updated to reflect the discontinuance of the Fentanyl patch. We will review all care plans on residents who have skin integrity issues to assure that the devices used for pressure relief are current and identified. We will review all residents who have pressure ulcers or had pressure ulcers in the last three months to assure that their care plan is current and up to date. We will review all residents with Fentanyl patches or who had Fentanyl patches in the last three months to assure that their care plans are up to date. We will review all care plans of residents who currently have tab alarms in place to assure the devices are placed on the care plan. We will review our policy on care planning with each of our care plan team members. We are changing our current	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 280	Continued From page 5 failed to identify interventions of pressure relieving boots and placement of a pillow under the right foot to relieve pressure. Resident #1's current care plan for falls identified ". . . at risk for falls R/T Unaware of safety needs, attempts self transfer at times. . . Interventions: . . . Personal Alarm: tab alarm to w/c [wheelchair] used to alert staff . . ." Observation on all days of survey showed a tab alarm on Resident #1's bed. Facility staff failed to include the use of a bed alarm on the care plan. - Review of Resident #2's medical record occurred on all days of survey and identified a Stage II pressure ulcer to his coccyx on 12/22/15. The current care plan for skin, revised 09/10/15, identified ". . . Hx [history] of Stage 3 pressure sore to left buttock--now healed . . ." Facility staff failed to identify Resident #2's current pressure ulcer on the care plan. - Review of Resident #5's medical record occurred on all days of survey and identified the physician discontinued the Fentanyl patch on 12/14/15. The current care plan for pain, revised 12/16/15, identified ". . . BLACK BOX WARNING - Fentanyl (duragesic) transdermal system . . . Potential adverse effects include blurred vision, bradycardia, confusion, dizziness, drowsiness, fatigue, headache, hypotension. . . ." Facility staff failed to update the care plan regarding the discontinued Fentanyl patch. - Review of Resident #4's medical record occurred on all days of survey and identified a pressure ulcer to the right ankle which healed on	F 280	care plan review process to include printing a hard copy of each care plan during their assessment period and asking our floor staff to review them. We will ask them to make changes on the paper form and then bring these changes to the care plan meeting to review and update as needed. To assure continued compliance, all resident's care plans will be reviewed on a quarterly basis to assure continued compliance. The DNS or designee will audit 5 random care plans per month for the first 3 months and then 5 random care plans quarterly for the next year. The results will be reported to the QA committee to assure compliance and changes in the process will be made if needed thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 280	Continued From page 6 12/01/15. Resident #4's current care plan for skin, revised on 10/14/15, identified ". . . I have skin integrity impairment R/T dementia E/B [evidenced by] healing stage III pressure ulcer to right outer ankle. . . . Receives dressing change and treatment daily. . . ." Facility staff failed to update the care plan to reflect the resident's healed pressure ulcer.	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: Based on observation, review of professional reference, review of manufacturer's instructions, and group and staff interview, the facility failed to follow professional standards of practice for 4 of 6 sampled residents (Resident #6, #8, #9, and #10) observed during insulin administration. Failure to correctly prime an insulin pen (Resident #9) has the potential for residents to receive an incorrect dose of insulin and failure to administer Novolog (a rapid-acting insulin) at the correct time (Resident #6, #8, #9, and #10) may result in low blood sugar levels (hypoglycemia). This practice may negatively impact all diabetic residents residing in the facility. Findings include: "Nursing 2015 Drug Handbook," 35th edition, Wolters Kluwer, Philadelphia, pages 759-761, reviewed on 01/21/16, stated the following, ". . . Novolog . . . Give 5 to 10 minutes before start of	F 281	The corrective actions taken to assist residents affected by this practice will be as follows: 1. All staff who administer insulin have been educated regarding the need to provide a meal or nourishment for Resident #8 within 5 to 10 minutes of the administration of his Novolog insulin. 2. All staff who administer insulin have been instructed on how to properly administer the Novolog Flex Pen for Resident #9 and the need to provide a meal or nourishment within 5 to 10 minutes of the administration. 3. All staff have been instructed on the need to provide a meal or nourishment for Resident #6 within 5 to 10 minutes of administration of the Novolog insulin. 4. All staff who administer diabetic medication have been instructed on the need to provide a meal or nourishment for	2/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 281	Continued From page 7 meal . . ." Review of the manufacturer's instructions for NovoLog FlexPen occurred on 01/21/16. 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 dose selector turns to zero. A drop of insulin should appear at the needle tip. If not, change the needle, and repeat the procedure. . . ." - During a group interview on 01/19/16 at 3:00 p.m., two residents (Resident A and B) identified staff often administer insulin before meals are served, creating a risk for low blood sugars. - Observation on 01/19/16 at 5:06 p.m. showed a licensed nurse (#3) administered 10 units of Novolog insulin to Resident #8. The resident received his meal at 5:48 p.m. (42 minutes after receiving insulin). - Observation on 01/20/16 at 11:24 a.m. showed a licensed nurse (#1) obtained Resident #9's Novolog FlexPen, dialed the FlexPen to 2 units, held the FlexPen downward, and performed the airshot. The nurse failed to perform the airshot while holding the pen in an upright position. The nurse (#1) administered 14 units of Novolog insulin to Resident #9. The resident received his meal at 12:07 p.m. (43 minutes after receiving insulin).	F 281	Resident #10 within 5 to 10 minutes of administration of the Novolog insulin. The facility identified all diabetic residents within the facility and from that list found 7 residents who have rapid acting insulin who would have the need to have a meal or nourishment within a certain time period. The facility also identified from the list of diabetic residents, two residents who use the Novolog pen. Each specific insulin's manufactured instructions were reviewed to see how soon a meal or nourishment must be served. Education was then given to the licensed nursing staff who are responsible for administering the medication on the need to provide a snack or nourishment within each manufacturer's designated time frames. Instructions were given to the licensed staff on the procedure to follow when administrating insulin with a flex pen. The Director of Nursing or the designee will monitor insulin administration by doing 10 random audits per month for the first quarter and then 10 random audits each quarter for the next year to assure a meal or nourishment is given within the manufacturer's designated time frame and/or if the insulin flex pen is being administrated properly. Results of these audits will be reported to the QA committee and changes will be made as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 281	Continued From page 8 - During an interview on 01/20/16 at 11:27 a.m., a licensed nurse (#4) stated she just finished administering Resident #6 and #8's insulin. Both residents received Novolog insulin. Resident #8 received his meal at 11:56 a.m. (approximately 29 minutes after the insulin administration) and Resident #6 received her meal at 12:06 p.m. (approximately 39 minutes after the insulin administration). - Observation on 01/20/16 at 5:16 p.m. showed a licensed nurse (#2) checked Resident #9's blood sugar. The nurse obtained Resident #9's Novolog FlexPen, dialed the FlexPen to 2 units, held the FlexPen downward, and performed the airshot. The nurse failed to perform the airshot while holding the pen in an upright position. The nurse (#2) administered 16 units of Novolog insulin to Resident #9. The resident received his meal at 5:47 p.m. (31 minutes after the insulin administration). - Observation on 01/20/16 at 5:24 p.m. showed a licensed nurse (#2) administered 12 units of Novolog to Resident #10. The resident received his meal at 5:45 p.m. (21 minutes after the insulin administration). Facility staff failed to ensure Resident #6, #8, #9, and #10 received a nourishment (carbohydrate) or meal within 10 minutes of rapid-acting insulin administration. This may result in unstable blood sugar levels for all insulin-dependent residents in the facility. During an interview on 01/21/15 at 9:15 a.m., an administrative nurse (#5) confirmed a meal or	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	**302 7TH AVE NE DEVILS LAKE, ND 58301**

(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 281	Continued From page 9 nourishment should be offered after the administration of a rapid-acting insulin.	F 281		