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	355099	A. BUILDING _____ B. WING _____	07/26/2018

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GOOD SAMARITAN SOCIETY - MOTT	401 MILLIONAIRE AVE MOTT, ND 58646

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 07/23/2018 and concluded on 07/26/18.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures For Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 1 sampled resident (Resident #22) with a newly diagnosed mental illness since the facility completed the initial PASARR on admission. Failure to complete a	F 644	F644 1) The corrective action accomplished for Resident #22 whose record lacked evidence the facility completed a Level II assessment following a newly diagnosed mental illness is that Ascend was contacted on 8/08/2018 to review the resident□s medical record to update the Level 1 screen for determination if a Level II evaluation must be performed.	8/16/18

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

Electronically Signed | 08/08/2018

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F 644	Continued From page 1 change in status assessment may result in the delivery of care and services that are inconsistent with resident's needs. Findings include: The North Dakota PASARR Provider Manual page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend [name of contracted service provider for screening process] to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of Resident #22's medical record occurred on all days of survey. The record showed an initial PASARR completed on 12/01/14 and identified dementia and no mental illness. The screening stated, ". . . The Level I Screen conducted for the above named individual determined that there was not evidence to suggest presence or known conditions of mental illness . . ." Resident #22's medical record identified diagnoses of dementia with behavioral disturbance (12/01/14), anxiety disorder (12/02/14), and unspecified psychosis not due to a substance or known physiological condition	F 644	2) The facility recognizes that all residents have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that Social Services has developed a tracking binder to ensure that all residents currently residing in the facility have the appropriate level of PASARR screen completed and follow up with Ascend as needed to determine if a Level II evaluation must be performed. In addition, the DNS will educate the Licensed Nursing Staff on or before 8/16/2018 to communicate to the Social Services regarding any newly diagnosed mental health illness for appropriate screening. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning Social Services or designee to monitor by using audits that all residents have the appropriate level of PASARR screen completed and on file. Audits will be done weekly x4, monthly x3, then quarterly x1 year. Results will be reported to the QA team with corrective action implemented. 5) Corrective action completion date: 8/16/2018	

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F 644	Continued From page 2 (05/28/15). The record lacked evidence the facility completed a Level II assessment following the new diagnosis of psychosis. During an interview on 07/26/18 at 9:45 a.m., a social service staff member (#1) confirmed the facility failed to submit a PASARR for Resident #22 following the additional diagnosis of psychosis.	F 644		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		8/16/18

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F 657	Continued From page 3 assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and review of facility policy, the facility failed to review and revise the comprehensive care plans for 2 of 12 sampled residents (Resident #16 and #22). Failure to revise the care plan limited the ability of the staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of facility policy titled "Care Plan" occurred on 07/26/18. This policy, revised November 2016, stated, ". . . The care plan will emphasize the care and development of the whole person, ensuring that the resident will receive appropriate care and services. A qualified team of 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 residents condition. This plan of care will be modified to reflect the care currently required/provided for the resident. . . ." - Review of Resident #16's medical record occurred on all days of survey. Diagnoses included dementia with behavior disturbance. Resident #16's admission Minimum Data Set (MDS), dated 5/21/18, identified the resident required supervision with locomotion on/off the unit, walking in room/corridor, eating, and extensive assistance with bed mobility. The current care plan stated, ". . . The resident has an ADL [activities of daily living] self care performance deficit R/T [related to] her	F 657	F 657 1) The corrective action accomplished for Residents #16 and #22 whose care plans were found to not reflect their current needs and/or behaviors is that the care plans for Resident #16 and #22 have been revised and updated on 08/07/2018 to address specific care needs and/or behaviors along with appropriate goals and interventions to manage them. In addition, the assignment sheet for Resident #16 has been revised on 8/07/2018 for accuracy. 2) The facility recognizes that all residents have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that Licensed Nursing Staff will be educated on or before 8/16/2018 by the DNS on the care planning process for care plans requiring revision to reflect current care needs and/or behaviors along with appropriate goals and interventions to ensure effective communication and continuity of care. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA nurse or designee to monitor by using audits to ensure that care plans are updated to reflect each resident□s current needs	

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F 657	Continued From page 4 Alzheimer's Disease with behavioral disturbances E/B [evidenced by] Aggressive behavior, Restlessness, Agitation and Confusion. . . . BED MOBILITY - Resident is able to position herself up in bed independently. . . Turn from side to side: Independently. . . Lying to sitting: Independent. . . Sitting to lying: Independent. . . EATING: STRENGTH: Resident is able to eat independently. . . TRANSFER - Transfer Between Surfaces: Independent. Supervision with ambulation. Review of the certified nursing assistant (CNA) "assignment sheet" identified Resident #16 as independent with eating, bed mobility and transfer in/out of bed. Review of the CNA documentation identified the following: * 7/14/18 through 7/25/18: Resident #16 incontinent of bladder 29 times and incontinent of bowels 14 times. * 7/19/18 through 7/25/18: Resident #16 dependent on staff 3 times and limited assist 2 times for eating. * 7/19/18 through 7/25/18: Resident #16 dependent on staff 10 times and extensive assist 2 times and limited assist two times for locomotion off unit. During an interview on 7/25/18 at 4:40 p.m., an administrative nurse (#2) indicated she was aware that Resident #16 had a decline in status/ADL's, however, she did not feel it was necessary to change care plan due to fluctuating ADL status during the period of medication adjustment.	F 657	and/or behaviors. Audits will be completed weekly x4, monthly x 3, then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented. 5) Corrective action completion date: 8/16/2018	

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F 657	Continued From page 5 The care plan failed to reflect Resident #16's change in condition/current needs. - Review of Resident #22's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance and anxiety. The current physician order stated, "May use bite sticks PRN [as needed] to help satisfy oral fixation (lip smacking behaviors/humming) as non-pharm [Non-pharmacological] interventions." Multiple observations throughout the day on July 23-24, 2018 showed Resident #22 chewing on her fingers. The progress notes showed the following: * 06/06/18 - ". . . Resident appears to be chewing on her fingers more frequently. She is no longer able to feed herself but if prompted she can take a drink by herself. . . ." * 05/29/18 - ". . . Resident does exhibit a dementia-based behavior of oral fixation and frequently chews on index finger; chew sticks available for intervention as needed. . . ." During an interview on 07/25/18 at 4:31 p.m., an administrative nurse (#2) stated Resident #22's treatment administration record (TAR) addresses the chew sticks, however, CNAs do not have access to the TAR. The care plan failed to address Resident #22's above behaviors and lacked specific goals/interventions for staff to manage the behavior.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		8/16/18

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F 658	Continued From page 6 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: MEDICATION ADMINISTRATION 1. Based on observation, review of professional reference, and staff interview, the facility failed to administer medications in accordance with acceptable standards of practice for 1 of 1 resident (Resident #5) who refused certain medications whenever leaving the building for appointments. Failure of the medication assistant II (MAII) to communicate medication refusals to the nursing staff, failure to ensure staff provided and documented education to the resident regarding effects of medication refusal, and failure of nursing staff to consistently notify the physician regarding refusals has the potential to result in adverse effects for the resident. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 10th Edition, 2016, Pearson, Boston, Massachusetts, page 773, stated ". . . Ten 'Rights' of Medication Administration: . . . Right to Refuse - Adult clients have the right to refuse any medication. The nurse's role is to ensure that the client is fully informed of the potential consequences of refusal and to communicate the clients refusal to the health care provider."	F 658	F 658 1) The corrective action accomplished for Residents #5 who refused certain medications whenever leaving the building for appointments is that Resident #5□s primary physician was updated on 8/02/2018 during physician□s nursing home visit regarding resident□s medication refusals and an order was obtained to allow these refusals. In addition, education was provided to Resident #5 during this visit regarding the potential adverse effects of these refusals and Resident #5□s care plan was updated to reflect the choice to refuse certain medications whenever leaving the building. The DNS will educate Licensed Nursing Staff, including Medication Aides II, at a Nursing Meeting on or before 8/16/2018 to review the Policy & Procedure titled Medication Administration, Including Scheduling and Medication Aides. Education to include the importance of effective communication by the Medications Aides II to report medication refusals to the licensed nursing staff and proper documentation on the Medication Administration Record (MAR). In addition, education will include contacting	

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F 658	Continued From page 7 Observation of medication pass occurred on 07/24/18 at 6:43 a.m. A MAII (#3) prepared medications for Resident #5, but omitted the scheduled Lasix (diuretic medication) and Fibercon (laxative) because the resident stated she did not want to take them as she was going out for an appointment. The staff member (#3) stated the resident "always requests these meds to be held when she goes out, as she does not want to have to use the bathroom all the time." The staff member documented the medications as not given due to the resident's request. The MAII (#3) failed to report Resident #5's refused medications to the nurse. Review of Resident #5's medical record occurred on July 24, 2018, and included diagnoses of hypertension, congestive heart failure, and constipation. Resident #5's medications included Lasix (diuretic) 60 milligrams (mg) three times a week and Lasix 40 mg four times a week for edema; MiraLax Powder (laxative) 17 grams three days a week and FiberCon (laxative) 625 mg two tablets every morning for constipation. Resident #5's current care plan stated, "Focus: Resident has Congestive Heart Failure E/B [evidenced by] edema to bilateral lower extremities. .. . Interventions: Monitor/document/report to health care provider PRN [as needed] any s/s [signs/symptoms]of Congestive Heart Failure . . . Focus: The resident is on diuretic therapy . . . Focus: Resident has the potential for constipation R/T [related to] decreased mobility . . ." Review of Resident #5's Nurses' Notes from January - July 24, 2018, identified the resident	F 658	the provider if the resident continues to choose not to take the medication for more than three doses so that further instructions or an alternate can be considered by the prescriber. The corrective action accomplished for Resident #15 whose neurological assessments were not completed per protocol is that the DNS will educate Licensed Nursing Staff at a Nursing Meeting on or before 8/16/2018 regarding the procedure titled Neurological Evaluation to include the facility□s protocol on neuro checks. 2) The facility recognizes that all residents have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that Licensed Nursing Staff and Medication Aides II will be educated on or before 8/16/2018 by the DNS to review the Policy & Procedure titled Medication Administration, Including Scheduling and Medication Aides. Education to include the importance of effective communication by the Medications Aides II to report medication refusals to the licensed nursing staff and proper documentation on the Medication Administration Record (MAR). In addition, education will include contacting the provider if the resident continues to choose not to take the medication for more than three doses so that further instructions or an alternate can be	

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F 658	Continued From page 8 refused the following medications due to going out for an appointment: Lasix: 03/29/18, 04/01/18, 04/18/18, 05/21/18, 05/22/18, 06/21/18, and 07/24/18 Fibercon: 04/18/18, 06/21/18, and 7/24/18 MiraLax: 01/09/18, 01/29/18, 04/18/18, and 05/21/18 Review of the resident's Physician Progress notes identified the following: 03/08/18 - ". . . [Resident #5] put herself on the list today because of increased edema. We had backed down her water pill due to urinary frequency during the day. She is on 40 mg every other day. . . . Plan: Increase her water pill back to daily. Ace wrap her legs for several hours during the course of the day to help with mechanical resolution of the edema. I think once her edema is better she will be able to fit back into her compression stockings and use those to keep the symptoms at bay." 04/12/18 - ". . . has had a couple of clinic visits in the interim for excess fluid which has improved greatly with an adjustment in her diuretic. . . ." 05/10/18 - "[Resident #5] is seen to discuss her Lasix dosage. She would like to be on less furosemide [Lasix]. . . . Plan: Decrease her Lasix to 60 mg three times per week and 40 mg four times per week, monitoring for increased weight or edema, in which case we will increase her Lasix again." Review of Resident #5's Nurses' Notes identified the following: 05/23/18 at 10:49 a.m. ". . . Weight this AM, 183# [pounds], up from 174.5 last week. Does have +2 pitting edema ankles et [sic] feet. Resident has had recent appts [appointments] out of facility et	F 658	considered by the prescriber. In addition, the Licensed Nursing Staff will be educated on or before 8/16/2018 on the Procedure titled Neurological Evaluation to include the facility□s protocol on neuro checks. A copy of the procedure titled Neurological Evaluation will also be included in the orientation packet for Agency Licensed Nursing Staff to provide education on the facility□s protocol on neuro checks. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA nurse or designee to monitor by using audits that medication refusals are reported to the charge nurse, documented on the MAR, and provider notification is completed if the resident continues to choose not to take the medication for more than three doses. In addition, the QA nurse or designee will monitor by using audits that the facility□s procedure titled Neurological Evaluation is followed per protocol. Both audits will be done weekly x4, monthly x3, then quarterly x1 year. Results will be reported to the QA team with corrective action implemented. 5) Corrective action completion date: 8/16/2018	

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F 658	Continued From page 9 [sic] asks that we hold Lasix those days. Requests apt [sic] with [name of physician] tomorrow . . ." The Clinic Referral note, dated 5/25/18, stated "Resident requested appointment R/T [related to] [increased] edema. Resident had appts out of facility last week so wouldn't take Lasix on those days so wt [weight] has increased. . . . Orders: Metolazone [diuretic] 2.5 mg [milligrams] . . . Call with wt Thursday. Weigh daily x [times] 1 week." During interview with an administrative nurse (#2) and a nursing staff member (#4) on the afternoon of 07/25/18, the staff members stated Resident #5 often communicated to the nurse when she refused medications or the medication assistant communicated the refusals to the nurse. The administrative nurse (#2) confirmed the medication assistant failed to document this communication. Staff failed to document when Resident #5 had been educated regarding the risks of medication refusal. NEUROLOGICAL CHECKS 2. Based on record review, and review of facility policy, the facility failed to provide care in accordance with professional standards/facility policy for 1 of 1 sampled resident (Resident #15) who experienced a fall. Failure to complete neurological assessments following a fall has the potential for a head injury to go undetected. Findings include: Review of facility policy titled "Neurological Evaluation" occurred on 07/26/18. This policy,	F 658		

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F 658	Continued From page 10	F 658		

revised September 2016, stated, ". . . To establish a baseline neurological status upon which subsequent evaluations may be compared and changes in neurological status may be determined . . . Following a resident event that results in a known or suspected head injury . . . After the completion of initial neurological evaluation with vital signs, continue with evaluations every 30 minutes x4, then every 8 hours x3 days or as directed by the provider. . . ."

Review of Resident #15 medical record occurred on all days of survey. A progress note, dated, 5/20/2018 at 6:30 p.m., stated, "[Resident #16's] son in room with her at this time, rings call light; upon entering room, nursing staff observes resident on the floor laying next to thebed [sic]. Resident's son states, 'She just wiggled herself out of her chair and slipped onto the floor. She hasthat [sic] pain in her right leg and she is always moving her legs and she fell onto the floor'. Fall was not witnessed by staff. . . . Neuro [neurological] checks and VS [vital signs] WNL [within normal limits]. . . . Vitals and neuros initiated and will continue per protocol."

The medical record and the neurological checks flow sheet identified staff completed neuro check as follows:
* 5/21/18: 1 neuro check completed at 11:10 p.m.
* 5/22/18: 2 neuro checks completed at 1:03 p.m. and 4:33 p.m.
* 5/23/18: 4 neuro checks completed at 12:33 a.m., 6:58 a.m., 2:56 p.m., and 10:56 p.m.

The facility staff failed to assess and document Resident #15's neurological status every 30 minutes x 4, then every 8 hours x 3 days after

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOTT	401 MILLIONAIRE AVE MOTT, ND 58646

(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 658	Continued From page 11 resident's initial neuro check was completed per facility protocol.	F 658		