STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355097	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY - LARIMORE	**501 E FRONT ST LARIMORE, ND 58251**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, the facility failed to ensure the residents' rights to request, refuse, and/or discontinue treatment for 6 of 16 sampled residents (Resident #2, #10, #17, #28, #32, and #136) reviewed for advance directives. Failure to discuss the residents' advance care planning wishes, including resuscitation status, procure physicians' orders reflective of the residents' wishes, and ensure signed documentation of the residents wishes by the resident or their authorized representatives limited the facility's ability to communicate to direct care staff and emergency personnel the residents' wishes in the event of a medical emergency. Findings include: Review of the facility policy titled Advance Care Planning and Advance Directives occurred on [DATE]. This policy, revised (NAME)2016, stated, . Purpose: To provide each resident the opportunity to make decisions regarding future medical care . Through [MEDICATION NAME] interaction and education, assist residents to make their own choices regarding well-being and treatment. To define a process to assist residents/families and healthcare decision-makers in advance care planning. - Review of Resident #2's medical record occurred on all days survey. The record showed the facility admitted Resent #2 on [DATE]. The record included a physician order stating, . Advance Directive: Do Not Resuscitate (DNR), Do not intubate (DNI) . The record lacked evidence of a discussion with the resident and/or resident's family/legal representative regarding what their current wishes entailed, including resuscitation. - Review of Resident #10's medical record occurred on all days of survey. The record showed the facility admitted Resident #10 on [DATE]. The record included a physician's order stating, . Advance Directive: DNR . The current Minimum Data Set (MDS), dated [DATE], showed Resident #10's cognition as severely impaired. A Hospital Admission History and Physical progress note, dated [DATE], stated, . Chief Complaint: Confused. The patient . noted to have tiredness, and confusion state . I had a detailed discussion regarding the code status with the patient and patient wants to be DNR. The record lacked evidence the resident's family/legal representative was included in the discussion regarding his code status. - Review of Resident #17's medical record occurred on all days survey. The record showed the facility admitted Resident #17 on [DATE]. The record included a physician order stating, . Advance Directive: DNI-DNR . The record lacked evidence of a discussion with the resident and/or resident's medical power of attorney (POA) regarding what their current wishes entailed, including resuscitation. - Review of Resident #28's medical record occurred on all days survey. The record showed the facility admitted Resident #28 on [DATE]. The record included a physician order stating, . Advance Directive: DNR . The record lacked evidence of a discussion with the resident and/or resident's family/legal representative regarding what their current wishes entailed, including resuscitation. - Review of Resident #32's medical record occurred on all days survey. The record showed the facility admitted Resident #32 on [DATE]. The record included a physician order stating, . Advance Directive: Do hospitalize, Do resuscitate (CPR) . The record lacked evidence the resident and/or resident's family/legal representative agreed with/signed the ND (POLST) Physician Orders for Life-Sustaining Treatment form which indicated his code status. - Review of Resident #136's medical record occurred on all days survey. The record showed the facility admitted Resident #136 on [DATE]. The record included a physician order stating, . Advance Directive: CPR . The record lacked evidence of a discussion with the resident and/or resident's family/legal representative regarding what their current wishes entailed, including resuscitation. During an interview on [DATE] at 2:09 p.m., an administrative staff member (#1) confirmed the facility does not have signed code status documents for every resident, and stated, The facility uses the physician order.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, and staff interview, the facility failed to develop a comprehensive care plan for 15 of 16 sampled residents (Resident #1, #2, #3, #7, #8, #9, #10, #17, #22, #23, #24, #28, #32, #34, and #136) and 1 of 2 closed records (Resident #36) reviewed. Care planning drives the type of care and services a resident receives and failure to develop a care plan that includes the care and services to be provided to the resident may negatively impact the resident's quality of life. Findings include: Review of the facility policy, titled Care Plan, occurred on 03/04/20. This policy, revised December 2019, stated, . Each resident will have an individualized, person-centered, comprehensive care plan that will include measurable goals and timetables, directed towards achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. - Review of Resident #1, #2, #7, #9, #10, #17, #22, #23, #28, #32, and #34 medical record occurred on all days of survey. The care plans failed to address the resident's and/or their representatives wishes regarding discharge planning. - Review of Resident #3's medical record occurred on all days of survey. A physician's order dated 02/27/19, identified Resident #3 received [MEDICATION NAME] (a diuretic) daily for hypertension. The resident's care plan failed to reflect the signs/symptoms of [MEDICAL CONDITION]/fluid retention, retention, possible side effects of the medication, and/or other interventions. Resident #3's care plan also failed to address the resident's and/or their representative's wishes regarding discharge planning. - Review of Resident #8's medical record occurred on all days of survey. A physician's order, dated 11/27/19, identified Resident #8 received [MEDICATION NAME] (a [MEDICAL CONDITION]) daily for anxiety. The care plan failed to reflect the signs/symptoms of anxiety and/or the possible side effects of the antianxiety medication. Resident #8's care plan also failed to address the resident's and/or their representative's wishes regarding discharge planning. - Review of Resident #24's medical record occurred on all days of survey. A physician's order, dated 06/26/19, identified Resident 24 received [MEDICATION NAME] (a diuretic) daily for [MEDICAL CONDITION]. The resident's care plan failed to reflect the signs/symptoms of [MEDICAL CONDITION]/fluid retention, possible side effects of the medication, and/or other interventions. Resident #24's care plan also failed to address the resident's and/or their representative's wishes regarding discharge planning. - Review of Resident #136's medical record occurred on all days of survey. The care plan and diet card identified Resident #136 on a regular diet, but failed to address the resident's food intolerances. Resident #136's care

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) plan also failed to address the resident's and/or their representative's wishes regarding discharge planning. During an interview on 03/04/20 at 8:44 a.m., when asked questions pertaining to Resident #136's food intolerances, a dietary staff member (#2) reported (Resident #136) chooses her own food. Her family brings in special cereal and other foods. The dietary staff member (#2) indicated she would add the resident's food intolerance to her care plan. During an interview on 03/04/20 at 10:45 a.m., an administrative staff member (#1) confirmed the discharge plans were not included in the residents' care plans.