STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355097	A. BUILDING _____ B. WING _____	11/08/2012

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

(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 11/05/12 and completed on 11/08/12, the sample included 2 residents for complete review, 8 residents for focused review, and 1 closed record for review.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility procedure, family interview, and staff interview, the facility failed to ensure facility staff ambulated 1 of 1 sampled resident (Resident #2) with orders for ambulation. Failure to ambulate or attempt to ambulate Resident #2 three times each day as ordered by the physician limited the resident's ability to achieve his highest physical, mental, and psychosocial well-being possible. Findings include: Review of the facility procedure, "Ambulation of Resident," occurred on 11/08/12. This procedure, revised November 2009, stated "PURPOSE, To assist resident in normal ambulation . . . To encourage exercise and promote physical stamina . . ." Review of Resident #2's medical record occurred on November 05-08, 2012. The facility admitted the resident in August 2012. The current	F 311		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rita J. Rolfes — TITLE: Administrator — (X6) DATE: 11-27-12

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 311	Continued From page 1 diagnoses included weakness, dementia, and anxiety. The admission Minimum Data Set (MDS), dated 08/20/12, identified severely impaired cognitive ability, walking in room and corridor did not occur during the assessment period, and the resident experienced functional limitation in range of motion of both lower extremities. Resident #2's medical record identified physical therapy services initiated following admission, improved ambulation, and discontinued, with physician's orders for a restorative therapy program three times each week. A physician's progress note, dated 10/10/12, stated "SUBJECTIVE: . . . Nursing staff tell me that he has been unmotivated on his exercises. He is off full rehab . . . ASSESSMENT AND PLAN: . . . We had a fairly stern lecture about him getting up and moving, working, complying with exercise when offered. . . ." Physician's orders, dated 10/10/12, included "Walk TID [three times each day] to tolerance." During interview, on 11/07/12 at 10:45 a.m., Resident #2's family member (#1), who was present at a consulting neurologist appointment on 11/06/12, reported one of the neurologist's recommendations was the resident "needs more walking." Observation throughout the survey failed to show nursing staff ambulated or attempted to ambulate Resident #2. Observation on 11/07/12 at 5:00 p.m. showed a CNA (#9) staff member pushing Resident #2 to the dining room in his wheelchair.	F 311	Resident #2 is being walked three times a day and staff are charting this activity. Staff will encourage and try to motivate resident #2 to ambulate but if he refuses this will be documented. The care plan has been updated. All residents that have orders to ambulate with staff have the potential to be affected. The "walk" list and care plans have been updated. Nursing staff received training on the importance of walking residents to help them maintain the highest physical, mental and psychosocial well-being possible. Nursing staff were re-educated that there is a "walk" list, that residents on the list need to be ambulated and that ambulation or a refusal need to be documented. The DON or designee will conduct an audit weekly for 4 weeks, then monthly for three months to ensure that residents with orders to ambulate are being ambulated. The audit will include visually watching for ambulation and a review of the charting. Results of audits will be reported to the Quality Assurance Committee for further recommendations.	12/13/12

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F 311	Continued From page 2 During interview, the CNA (#9) reported she did ambulate the resident a short distance until he became tired and sat in the wheelchair. The CNA (#9) reported staff document the episodes of ambulation on the electronic medical record. Review of the nursing staff ambulation documentation in the electronic medical record, on 11/08/12 at 8:30 a.m., with an administrative nursing staff member (#7) and a supervisory nursing staff member (#8), for the period October 20, 2012 to November 07, 2012 (19 days), showed the facility staff ambulated Resident #2, 11 of 57 times (19%) during the period. Resident #2's physician, the consulting neurologist, and the resident's family member expressed concerns of limited ambulation by facility staff. Failure of facility staff to ambulate Resident #2 may have a negative effect in the resident's ability to maintain or improve his ambulation.	F 311		
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, record review, review of facility procedures, and staff interview, the facility	F 323		

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F 323	Continued From page 3 failed to ensure 3 of 5 sampled residents observed transferred with a gait belt (Resident #2, #7, and #10) received adequate assistance and proper use of gait belts. Transferring and assisting residents by grasping the upper arms or lifting under the residents' shoulders may cause injury or pain. Failure to properly use the gait belt placed the residents and the staff members at risk of injury. Findings include: Review of the following facility procedures occurred on 11/08/12. *The procedure, "Gait (Transfer) Belt," revised January 2009, stated "PURPOSE, To safely transfer or ambulate resident; To aid resident in maintaining balance; To avoid injury to both resident and staff member. NOTE: Gait belts used unless medically contraindicated. PROCEDURE . . . 4. Make sure belt is securely buckled so it does not slide. . . . 5. When holding the belt an underhand grasp should be used. 6. Transfer or ambulate resident and remove belt. . . ." *The procedure, "Ambulation of Resident," revised November 2009, stated "PURPOSE . . . To prevent accidents when ambulating resident . . . PROCEDURE, 1. . . . assist resident as needed . . . 2. Use gait belt, if necessary, around resident's waist to help resident maintain balance. . . ." - Review of Resident #2's medical record	F 323	Gaits belts are being used according to facility procedure on residents #2, #7 and #10. The nursing department has received training from the occupational therapist on the specifics of how to use the gait belt with each of these residents. All residents that need assist with transfers have the potential to be affected. The nursing department has been educated on the importance of always using gait belts. An occupational therapist demonstrated the proper use of gait belts for different types of transfers. An audit will be created to monitor the appropriate use of a gait belt. The DNS or designee will audit 3-5 transfers a week for four weeks, then monthly for 3 months to ensure compliance with gait belt usage. Results of audits will be reported to the Quality Assurance Committee for further recommendations.	12/13/12

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F 323	Continued From page 4	F 323		

occurred on November 05-08, 2012. The facility admitted the resident in August 2012. Current diagnoses included weakness, dementia, and anxiety. The admission Minimum Data Set (MDS), dated 08/20/12, identified the resident required assistance of two or more persons for transfers, walking in room and corridor did not occur, and the resident experienced functional limitation in range of motion of both lower extremities.

Resident #2's current care plan, dated 08/28/12, stated "Problems . . . Alteration in mobility r/t [related to] weakness, peripheral neuropathy . . . Approaches . . . Transfers: Extensive assist of 1-2. . . .;" and modified 10/10/12, "Ambulate TID [three times each day] to tolerance. . . ."

Observations of facility staff providing care for Resident #2 identified the following:
*11/05/12, 4:25 p.m. - Two Certified Nursing Assistants (CNA) (#1) and (#2) assisted the resident to stand at the toilet to void and return to his wheelchair by grasping his upper arms. The CNAs failed to apply a gait belt.
*11/06/12, 8:30 a.m. - Two CNAs (#3 and #4) placed a gait belt around Resident #2's waist, assisted him to stand from his wheelchair to his front wheeled walker, and walk up an inclined ramp into the facility van. The CNA (#3) held the resident's upper arm and under his arm to assist him to stand and during the ambulation. The CNA (#3) failed to use the gait belt, placing the resident at risk for a fall or injury.

- Review of Resident #7's medical record occurred on November 05-08, 2012. The facility admitted the resident in January 2003. The

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F 323	Continued From page 5	F 323		

resident's current diagnoses included rheumatoid arthritis and dementia. The resident's quarterly MDS, dated 09/27/12, identified the resident required extensive assistance of two or more persons for transfers, walking in room and corridor did not occur, the resident experienced functional limitation in range of motion of both upper and both lower extremities, and the resident received scheduled, as needed, and non-medical pain interventions.

Resident #7's current physician medication orders included;
*Fentanyl patch (opioid pain medication), 12 micrograms, change every third day;
*Lorcet, 10/650 (10 milligrams hydrocodone (opioid pain medication)/650 milligrams acetaminophen), one tablet, TID;
*Tylenol (acetaminophen) 650 milligrams, every four hours, as needed.

Resident #7's current care plan, dated 10/04/12, stated "Problems . . . Alterations in mobility r/t weakness, pain @ [at] intervals, osteoporosis, RA [rheumatoid arthritis] . . . Approaches . . . Extensive assist of two with transfers and use of gait belt. . . ."

Observations of facility staff providing care for Resident #7 identified the following:
*11/06/12, 9:00 a.m. - Two CNAs (#4 and #5) applied a gait belt to the resident's waist, assisted her to stand from her bed and pivot transfer to her wheelchair, then stand from the wheelchair in the bathroom. One CNA (#4) assisted Resident #7 by grasping her upper arm and under her arm during the transfers, and failed to use the gait belt.

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F 323	Continued From page 6 *11/06/12, 12:38 p.m. - Two CNAs (#4 and #6) applied a gait belt to the resident's waist, assisted her to stand from her bed, pivot transfer to her wheelchair, then stand from the wheelchair in the bathroom. One CNA (#4) assisted the resident by grasping her upper arm and under her arm during the transfers, and failed to use the gait belt. Grasping Resident #7 under her arm placed her at risk of experiencing increased pain related to her rheumatoid arthritis and limited range of motion. - Review of Resident #10's medical record occurred on November 07-08, 2012. The facility admitted the resident in May 2011. The annual MDS, dated 08/13/12, identified the resident required limited assistance of one person for bed mobility and transfers. Resident #10's current care plan, dated 08/21/12, stated "Problems . . . Alteration in mobility r/t weakness, m/b [manifested by] need for assist with all areas of mobility. . . . Approaches . . . Limited assist with bed mobility of 1-2. Limited assist with transfers with gait belt 1-2 [persons]. . . ." Observation, on 11/07/12 at 3:20 p.m., identified a CNA (#10) assisted Resident #10 from her bed to the bathroom and back to bed, using a gait belt. The CNA (#10) then assisted Resident #7 to move up in bed by grasping and pulling under her left arm and shoulder, not using the gait belt. During interview, on 11/08/12 at 8:15 a.m., an administrative nursing staff member (#7) and a supervisory nursing staff member (#8) confirmed the facility staff should use gait belts to assist	F 323		

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F 323	Continued From page 7 residents to stand for toileting and during transfers and should not grasp and pull on the residents' arms or shoulders during transfers or bed mobility activities.	F 323		