STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOHALL	602 E MAIN ST MOHALL, ND 58761

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 05/04/15 and completed on 05/07/15, the sample included 2 residents for complete review, 9 residents for focused review, and 1 closed record for review.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and review of the facility's procedure, the facility failed to ensure 1 of 1 sampled resident (Resident #1) observed with a restraint remained free from physical restraints imposed for the purpose of convenience, and not required to treat the resident's medical symptoms. Failure to attempt alternatives and monitor for effectiveness prior to the placement of a restraint, monitor the effectiveness and continued need for the restraint, follow the planned schedule for when to apply the restraint, and determine the frequency of how often staff should observe the resident while restrained, placed the resident at risk for loss of independence and injuries. Findings include: Review of the facility procedure titled, "Physical Restraints" occurred on 05/07/15. This policy, dated 10/13, stated, "Purpose: To ensure the	F 221	**F – 221 Right to be free from Physical Restraints** **1. Resident #1 was re-assessed and the Physical Device and Restraint Assessment UDA completed 5/27/15. Tray will be removed at Devotions and at Cluster Time. Care plan was updated to include the planned schedule for application of restraint, frequency of use and observation required while restrained on 5/27/15.** **2. All residents who have Physical Restraints have the potential to be affected.** **3. A. Good Samaritan Procedure Physical Restraints, Physical Restraint Alternatives, and Risks to Residents when a Physical Restraint is used, were reviewed at the Nursing In-service 5/19/15 – 5/21/15.** This form was signed on 05/27/15 per Phone conversation with Kimberly Gordon, LNHA on	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly Gordon — TITLE: LNHA — (X6) DATE: 6/1/15 @ 2:05pm (JS)

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 221	Continued From page 1 appropriate use of restraints . . . If the device, material or equipment cannot be removed easily by the resident and restricts freedom of movement or normal access to one's own body, then this is a restraint and this procedure must be followed . . . 3. Throughout use of the restraint, the following must be completed: . . . b. Observe restrained residents. Frequency of this observation is determined by the care plan team. c. The interdisciplinary team or reduction committee must continually monitor and evaluate the use of the restraint and pursue the least restrictive device with a goal to use alternatives whenever possible (such as close observation during a special small group event or during meal times that may preclude the use of the restraint). . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, unspecified episodic mood disorder, generalized anxiety disorder, and adjustment disorder with mixed disturbance of emotions and conduct. Review of Resident #1's annual MDS (Minimum Data Set) assessment, dated 01/31/15, identified the resident with short and long term memory impairment, severely impaired daily decision making skills, experienced constant inattention, required extensive assistance of two staff members for transfers, walking in her room and the corridor and locomotion on the unit. It also identified the resident had no falls since the previous assessment and used a chair restraint daily which prevented her from rising. Review of Resident #1's Physical Restraint CAA (Care Area Assessment) (a further assessment of	F 221	**B. Unit Managers/ MDS Coordinators reviewed the Physical Restraints Procedure with focus on Non-Emergency Restraint use, documentation using the physical device and restraint Assessment UDS, and Care-plan interventions that must be followed throughout use of the restraint, and quarterly Physical Device and Restraint Review.** **4. A. The Unit managers will be responsible for monitoring/ auditing proper restraint use, observation of resident, and frequency through weekly monitoring x4, then monthly x2, then quarterly through the year and then PRN. Results will be immediately reported to the DON. If concerns are identified, immediate corrective action will be implements.** **B. Audits will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, trends to make recommendation as needed. The QAPI Committee will use the Model for Improvement for any opportunities for improvement identified.**	

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F 221	Continued From page 2 the MDS), dated 01/31/15, identified the resident used a reclining gerichair/wheelchair (reclining wheelchair) with a tray that would be considered a physical restraint. The CAA identified the resident with poor attention span, impulsivity and confusion related to Alzheimer's disease; made no attempts to get out of the chair; staff periodically took the resident to the bathroom then sat her in the recliner; the resident "does well" in the recliner; and had no signs or symptoms of depression. Review of the Quarterly MDS assessment, dated 04/29/15, identified the resident with short and long term memory impairment, severely impaired cognitive skills for daily decision making, experienced constant inattention, needed extensive assistance of two staff for transfers, walking in her room and the corridor, and locomotion on the unit. The MDS identified the resident experienced no falls since the previous MDS assessment dated 1/31/15 and used a chair restraint daily which prevented her from rising. Resident #1's comprehensive care plan stated, ". . . Focus: The resident uses physical restraint: Reclining w/c [wheelchair] with tray R/T [related to] confusion, weakness E/B [evidenced by] Fall risk. . ." Interventions included, ". . . May use reclining gerichair with tray before and during meals and snacks, Use recliner after meals. Change position, remove from gerichair, ambulate or toilet at least every 2 hours." The facility failed to care plan how often staff needed to observe the resident while in the restraint as directed by the facility's policy. Review of a facility form titled "Physical Device and Restraint Review," dated 11/15/14, identified	F 221	**5. Date of correction**	**6/4/15**

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F 221	Continued From page 3	F 221		

the resident used a gerichair with a tray due to the resident having unsteady gait, frequent falls, and attempts to self transfer. The review identified the restraint effective due to no falls, improved alertness and ability to ambulate; placement on a restorative ambulation program; staff now transferred the resident to the recliner after meals; the resident no longer attempted self transferring; and the time spent in the gerichair with the tray decreased on 11/15/14 to before and during meals, and snacks. The restraint reviews, dated 01/28/15 and 4/29/15, showed the same findings, with no further attempts or alternative methods to the restraint, or reduction of time while in the restraint.

Observation on 05/04/15 at 5:03 p.m. showed Resident #1 in a gerichair with a large tray attached to the front in the south living room. While residents attended an activity regarding springtime, Resident #1's gerichair sat up toward the table by the other residents. The resident looked around, mumbled at times, closed her eyes, and touched her face.

Observation on 05/05/15 at 8:10 a.m. showed Resident #1 in her gerichair in front of a dining table in the main dining room with the large tray attached to her gerichair. An activities staff member (#3) sat next to the resident and assisted the resident to eat, sometimes setting the resident's food plate on the tray, and assisting the resident to feed herself, and other times, the staff member sat the food on the main table, and fed the resident. The staff member (#3) sat with the resident until the resident finished eating her meal, but never attempted to remove the tray while closely observing the resident as per the facility policy. At 8:45 a.m., this staff (#3) moved

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F 221	Continued From page 4	F 221		

the resident, and positioned her in an empty area near the front of the dining room where the resident sat until an activities staff member (#3) guided her and other residents in a ball toss activity. During the activity the tray remained in place, attached to the wheelchair.

Observation on 05/05/15 at 3:00 p.m., showed the resident in the gerichair with the tray attached in the south living area in front of the bird aviary. The resident sat with eyes closed, then opened her eyes, looked up, mumbled, and touched her face and the tray. At 3:37 p.m., a CNA (certified nurse aide) (#5) sat down next to the resident and offered a snack, which the resident pushed away several times. This CNA (#5) reported the resident did not want the snack, and disposed of the snack. The resident remained in front of the aviary in her chair with the tray attached to the wheelchair.

During interview on 05/05/15 at 2:45 p.m., when asked how she would know how to care for residents, the CNA (#5) reported she asked other staff and looked at the Kardex (an electronic, easily accessible version of the care plan).

During interview on 05/06/15 at 4:20 p.m., a CNA (#4) reported they did not have a set schedule for when to apply the tray, and just tried "to mix it up" by having the resident in the recliner sometimes and in the gerichair or bed other times. The CNA (#4) also reported she applied the tray anytime the resident sat in the gerichair, including during activities or when transporting to another location in the facility.

During interview on 05/07/15 at 9:45 a.m., an administrative nursing staff member (#2) reported

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F 221	Continued From page 5 the facility staff used the gerichair and tray to prevent the resident from rising at least since 01/31/14. The staff member stated the resident tried to frequently self-transfer, and had falls. This staff member (#2) reported they decreased the use of the tray in the gerichair on 11/15/14, utilizing the recliner more during the day. The staff member (#2) reported she thought this worked well, but had not attempted any other reductions since 11/15/14. This staff member (#2) reported meal and snack times deemed the most appropriate times to have the tray in place because the resident grabbed at items on the table, and staff could place the resident's specific items on the tray for her. The staff member stated the resident needed assistance and sat at the assisted table; did not know if staff had attempted to sit the resident up to the table without the tray, and did not know if staff had tried the resident in the gerichair without the tray at times when not at meals. This staff member reported the aides are trained and know the tray needed to be on specifically before and during meals and snacks. The staff member reviewed the Kardex, and reported the Kardex did not include the use of the gerichair and tray or when it is to be used. The facility failed to follow the plan for when the facility deemed the restraint necessary, failed to monitor the effectiveness of the daily use of the restraint, and failed to consistently make efforts to eliminate its use.	F 221		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable	F 246	**F-246 Reasonable Accommodation of needs/preferences**	

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F 246	Continued From page 6 accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide reasonable accommodations of individual needs and preferences for 1 of 10 sampled residents (Resident #4) who utilized wheelchairs. Failure to provide foot support in the wheelchair has potential to cause the resident to decline in her abilities to remain independent, cause pain to her legs, hips, and back, and may contribute to pressure sores. Findings include: Review of the facility policy/procedure titled "Restorative Nursing Programs . . . Wheelchair Positioning," occurred on 05/07/15. This policy/procedure, dated February 2013, stated, "PURPOSE, To develop proper body alignment for residents in wheelchairs . . . Normal Sitting Postural Alignment . . . 4. Feet rest flat on a support. . . ." Review of Resident #4's medical record occurred on May 04-07, 2015. A quarterly Minimum Data Set, dated 03/21/15, identified Resident #4 required extensive assistance of one staff person for bed mobility and transfers. The current care plan identified the following focus/interventions:	F 246	**1. Resident #4 was given a different wheel chair and foot rests adjusted to fit so feet are flat on the foot pedals.** **2. All resident who use wheelchairs have the potential to be affected.** **3. A. Good Samaritan Policy/procedure for correct wheelchair position will be reviewed and in-serviced to the nursing department 5/19/15 – 5/21/15.** **B. All residents who are in a wheelchair will be assessed for correct wheelchair positioning 5/13/15 – 5/22/15 and corrections made as needed.** **4. A. The Physical Therapy department will be responsible to audit resident in wheel chairs with weekly care plans x3 months beginning 6/1/15, and then quarterly audits through one year, then PRN. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented.**	

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F 246	Continued From page 7 * "The resident is at risk for falls. . . Monitor resident for significant changes in gait, mobility, positioning device, standing/sitting balance and lower extremity joint function. . . ." * "The resident has limited physical mobility . . . Mobility: Resident uses wheelchair for locomotion when feeling weaker or more subdued. . . ." Observations of Resident #4 showed the following: * 05/04/15, during the supper meal, the resident sat in her wheelchair with her feet positioned unsupported behind the foot pedals. The resident eats a table where assistance is provided. * 05/05/15 and 05/06/15, during breakfast, lunch and supper, the resident sat in her wheelchair with her feet positioned unsupported behind the foot pedals for part or all of the meal. * 05/05/15 at 4:15 p.m., two CNAs (#16 and #17) assisted the resident into her wheelchair after personal cares. When the resident sat with her hips all the way back in the wheelchair her feet could not reach the foot pedals. The CNAs (#16 and #17) stated since the facility provided the new seat cushion for the resident, her feet have not touched the foot pedals. * 04/07/15, during the breakfast meal, the resident sat in wheelchair with her feet positioned unsupported behind the foot pedals. These observations showed Resident #4's feet unsupported when in the wheelchair. Sitting with her feet unsupported can increase the resident's risk of sliding forward in the chair, resulting in shear force on the buttocks with potential for skin damaged to the buttock and/or coccyx. During an interview on the morning of 05/07/15, an administrative nursing staff member (#1)	F 246	**B. Physical Therapy Assistant will submit audits that will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, trends to make recommendation as needed. The QAPI Committee will use the Model for Improvement for any opportunities for improvement identified.** **5. Date of correction**	**6/4/15**

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F 246	Continued From page 8 agreed facility staff failed to provide foot support for Resident #4.	F 246		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) 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, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 2 sampled residents (Resident #5) within 14 days after a significant change in the resident's physical condition. Failure to recognize a significant change in the resident's condition limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate care approaches. Findings include:	F 274	**F – 274 Comprehensive Assessment after Significant Change** **1. Resident #5 MDS was reviewed and a Significant Change unscheduled MDS will be completed with The ARD date of 5/11/15. The care plan will be reviewed to accurately reflect the resident's current level of assistance for ADL's.** **2. All resident who have a significant decline or improvement in their status have the potential to be affected.** **3. A. The Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual procedure and information involving Significant Change in Status Assessment will be reviewed by the Unit Manager/ MDS Coordinator by 5/21/15.**	

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F 274	Continued From page 9 The Centers for Medicare and Medicaid Services (CMS) "Long-Term Care Facility RAI User's Manual," Version 3.0, October 2014, pages 2-20 and 2-23 states, ". . . A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention . . . (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and /or revision of the care plan. . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g. [example given], two areas of ADL [activities of daily living] decline or improvement). . . ." Review of Resident #5's medical record occurred on all days of survey. Diagnoses included diabetes mellitus, peripheral vascular disease, foot ulcer with surgical repair, and osteomyelitis. Resident #5's quarterly Minimum Data Set (MDS), dated 01/16/15, identified verbal and other behaviors occurring on one to three days of the look back period; independence with bed mobility and transfers; limited assistance for dressing; extensive assistance for personal hygiene; occasionally incontinent of bladder, and continent of bowel. Review of the resident's medical record identified he was hospitalized from 03/20/15 to 03/25/15. The quarterly MDS, dated 04/11/15, identified Resident #5 declined in several areas: extensive assistance for bed mobility and transfers, extensive assistance for dressing, and frequently incontinent of bladder and bowel. The resident improved in the following areas: no behaviors noted and required supervision for personal hygiene.	F 274	**B. The nursing department will be in-serviced in what triggers a significant change so they can communicate changes to the Unit Managers/MDS coordinators 5/19/15 – 5/21/15.** **C. The MDS Coordinators will review the Resident Communication Kardex and High Risk Progress Notes weekly to ensure a resident doesn't experience a significant change for either a decline of an improvement according to the RAI definition of a Significant Change in Status in ADL's for all the resident's.** **4. A.The MDS Coordinator will develop an audit to monitor for possible significant changes on MDS assessments every week x4, then monthly x2, then quarterly x2, following with PRN audits as needed. If concerns are identified re-education will be implements.** **B. The MDS Coordinator will submit audits that will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, trends to make recommendation as needed. The**	

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F 274	Continued From page 10 The record lacked evidence staff completed a SCSA following Resident #5's decline in functional status, and continence.	F 274	**QAPI Committee will use the Model for Improvement for any opportunities for improvement identified.**	
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 policy, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 2 of 7 sampled residents (#2 and #11) observed transferred/ambulated with a gait belt. Failure to use a gait belt properly during transfers and ambulation places residents at risk of accidents and injury. Findings included: Review of the facility policy titled "Gait (Transfer) Belt" occurred on 05/07/15. 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: . . . 3. . . . Keep the belt low on the resident's waist. 4. Make sure belt is securely buckled so it does not slide. Belt should	F 323	**5. Date of correction** **6/4/15** **F – 323 Free of Accident hazards/Supervision /Devices** **1. A. Resident #2 will no longer be transferred with a gait belt starting 5/28/15 due to system change.** **B. Resident #11 was evaluated by the Restorative Nurse 5/18/15. Restorative Ambulation discontinued and care plan updated. Mobilization UDA completed 5/27/15 and care planed for Sit-to Stand.** **2. All residents who need physical assistance are to ambulate with a gait belt will have the potential to be affected.** **3. A. Certified Nursing Assistants and Nurses were in-serviced 5/19/15 – 5/21/15 with the focus on GSS Gait Belt Procedure and proper gait belt application and use during ambulation.**	

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(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 323	Continued From page 11 not be twisted and should be snug enough so you can get your fingers under it. This will prevent the belt from sliding up under the breasts, rib cage or axillae. . . .7. Do not use the pants/slack belt as a gait (transfer) belt. Upward movement of the belt can cause male residents severe pain. . . ." Review of the facility policy titled "Ambulation of Resident" occurred on 05/07/15. This policy, dated 11/2013, stated, ". . . Note: Assisting Visually Impaired Residents to Walk: . . . Walk on the side that resident prefers and walk at resident's pace. . . ." Review of Resident #2's medical record occurred on all days of survey. Diagnosis included dementia and aftercare for traumatic fracture of hip. The current Minimum Data Set (MDS), dated 02/05/15, identified long and short term memory problems and extensive assist of two or more staff with transfers and ambulation. The care plan identified the following focus/interventions * "The resident has limited physical mobility R/T fx [fracture] right hip [no surgical intervention] E/B [evidenced by] Weakness. . . . Provide assistance of two staff members and gait belt with mobility as needed. . . ." Observation on 05/05/15 at 10:00 a.m. showed three CNAs (#11, #12 and #13) assisted Resident #2 from the wheelchair to the bed. During the transfer, one CNA (#12) assisted Resident #2 by using the gait belt and pulling on the back of the resident's pants. The gait belt slid up to mid chest level on Resident #2. Observation on 05/05/15 at 10:30 a.m. showed	F 323	**B. System Change: Nursing staff were educated in the Safe Resident Handling Program 5/19/15 – 5/21/15. Staff transfers with a gait belt will be eliminated starting 5/28/15. The Stand Aid or Sit-To-Stand lift based on the resident's needs will be used. Gait belts will be used to stabilize residents while walking only.** **C. All resident transfer ability was re-evaluated using the Mobilization Support Data Collection Tool between 5/20/15 – 5/28/15 and care plans were reviewed to accurately reflect the current level of assistance.** **4. A. The DON or designee will audit proper application of the gait belt during ambulation by staff weeklyx2, then every 2 weeks x2, then monthly x2 and quarterly thru the year, then PRN.** **B. Results will be reported to DON. If concerns are identified, immediate corrective action will be implemented.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	05/07/2015

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F 323	Continued From page 12 two CNAs (#11 and #12) assisted Resident #2 from the bed to the wheelchair. During the transfer, one CNA (#11) used the gait belt and the back of Resident #2's pants to transfer the resident. Observation on 05/05/15 at 2:23 p.m. showed two CNAs (#14 and #15) assisted Resident #2 from the wheelchair to the recliner. During the transfer, both CNAs used the gait belt and the back of Resident #2's pants to transfer the resident. Observation on 05/05/15 at 3:28 p.m. showed two CNAs (#15 and #16) assisted Resident #2 from the wheelchair onto the toilet. During the transfer, both CNAs (#15 and #16) used the gait belt and the back of Resident #2's pants to transfer the resident onto the toilet. During the transfer, off of the toilet, two CNAs (#14 and #16) used the gait belt and the back of Resident #2's pants. The loose, twisted gait belt slid up to the resident's axillae area. During an interview on 05/07/15 at 9:55 a.m., an administrative nurse (#2) stated staff are trained not to grab and pull the resident's pants during a transfer. - Review of Resident #11's medical record occurred May 06-07, 2015. A quarterly MDS, dated 03/21/15, identified the resident with impaired vision, did not wear glasses, and required extensive assistance of two staff for transfer and to walk in her room and/or the corridor. The current care plan identified the following focus/interventions: * "The resident has an ADL [activities of daily	F 323	**C. Audits will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance and trends to make recommendation as needed. The QAPI Committee will use the Model for Improvement for any opportunities for improvement identified.** **5. Date of Correction**	**6/4/15**

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F 323	Continued From page 13 living] self care performance deficit . . . Ambulation: Resident needs 2 staff with gait belt for ambulation . . ." * "The resident has a need for restorative intervention due to limited physical mobility/impaired cognition R/T dementia E/B unsteady gait . . . Nursing Rehab [Rehabilitation] #1: Walking with 2 staff assist, distance as tolerated to increase endurance; at least every shift . . ." Observation on 05/06/15 at 12:47 p.m. showed two CNAs (#9 and #10) ambulated Resident #11 from the dining room to a recliner in the North lounge. The CNAs (#9 and #10) applied a gait belt around the resident's waist, each CNA (#9 and #10) held onto the gait belt and one of the resident's hands, walking beside the resident. When the resident's gait slowed, the CNAs (#9 and #10) moved ahead of Resident #11 causing her to lean forward, shorten her steps and drag her toes on the carpet.. The CNAs (#9 and #10) stopped once directing Resident #11 to lift her head, to watch where they were going, and to pick up her feet while walking. The CNAs (#9 and #10) failed to step back to Resident #11's side and remained out in front of her. The CNAs (#9 and #10) cued the resident to walk again and Resident #11 remained in the bent forward, arms spread out, with the CNAs (#9 and #10) cueing her to lift her head and take longer steps for the rest of the walk. During an interview on 05/06/15 at 5:37 p.m., an administrative nursing staff member (#1) agreed the method used for the ambulation of Resident #11 was not safe for the resident.	F 323		
F 363	483.35(c) MENUS MEET RES NEEDS/PREP IN	F 363	**F-363 Menus meet resident needs/ prep**	

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F 363 SS=E	Continued From page 14 ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, review of the menus, review of facility policy and procedure, and staff interview, the facility failed to meet the nutritional needs of residents by serving incorrect portion sizes during 3 of 3 meal service observations (noon meals on May 05 and 06, 2015 and the evening meal on May 05, 2015) which resulted in the nursing home residents receiving the incorrect portion sizes. Failure to serve appropriate portion sizes placed residents at nutritional risk. Findings include: Review of the facility procedure titled "Small and Large Portions," occurred on 05/06/15. This procedure, dated February 2013, stated, "PURPOSE, To honor resident preferences regarding food portions. . . . PROCEDURE, . . . 2. Menu extensions will be planned for large and small portions . . . A center-registered dietician (RD) will approve the menu extension or customized plan for the resident. 3. The appropriate scoops/ladles will be available on the tray line to accommodate the small/large portion extensions. . . ."	F 363	**1. Corrective action completed 5/15/15 for all residents to utilize 3 scoop sizes on tray line according to GSS Policy Portion Control and Procedure for large and small portions including altered foods and Portion Control Guidelines One scoop will be standard scoop size as indicated on Standardized recipes. The appropriate scoops/ladles will be available on the tray line to accommodate resident's preference of small and large portions.** **2. Residents identifies as potentially affected by this deficient practice are those with a small of large portion preference.** **3. A. Dietary staff was educated 5/26/15 to the Good Samaritan Policy for Portion Control and Procedure for large and small Portions including altered textured foods. Staff will follow the Portion Control Guideline found in Good Samaritan Policy and Procedure when serving altered textured foods which is posted in the kitchen next to the tray line.** **B. System change to utilize 3 scoop sizes on tray line according to**	

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F 363	Continued From page 15 - Observations of tray line service occurred on 05/05/15 at 11:45 a.m., 05/05/15 at 5:45 p.m. and on 05/06/15 at 11:47 a.m., and identified the following: * A dietary staff member (#6) used a 1/2 cup scoop and served both the small and large portions of the vegetable and mashed potatoes; used a 1/4 cup scoop to serve the alternate vegetable; and used tongs to serve the chopped and ground chicken. The menu identified staff are to use a 1/2 cup scoop for vegetables not the 1/4 cup and failed to identify a scoop size for the chopped and ground chicken. * A dietary staff member (#7) used a 1/2 cup scoop to serve both the small and large portions of the cheesy tuna casserole. The menu identified 3/4 cup as the portion size for the cheesy tuna casserole. All residents served the casserole received 1/2 cup rather than 3/4 cup. * A dietary staff member (#6) used a 1/2 scoop and served both the large and small portions of whipped potatoes and vegetables; a 1/4 cup scoop for the alternate vegetable; and used tongs to serve the chopped and ground Salisbury steak. The dietary staff member (#6) stated she uses less than a full scoop of potatoes and vegetable for small portions and places enough chopped or ground meat on the plate to take up the same space as a whole piece of chicken or steak. During an interview on 05/07/15 at 10:15 a.m., a dietary management staff member (#8) confirmed dietary staff used the wrong scoop/ladle when serving the above food items. This staff member (#8) stated they had not established small and large portions with the RD, and had not established scoop sizes for the chopped and ground meats.	F 363	**Good Samaritan Portion Control Policy to include altered textured foods. One scoop will be standard scoop size for regular and altered textured foods as indicated on Standardized recipes and Menu Extensions. The appropriate scoops/ladles will be available on the tray line to accommodate resident's preferences of small or large portion.** **4. A.To ensure on going effectiveness Dietary Director will audit resident potentially affected to ensure scoop size is equivalent to portion size preferences including altered textured diets weeklyx4, then monthly x2, then quarterly x2.** **B. Audits will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, trends to make recommendation as needed. The QAPI Committee will use the Model for Improvement for any opportunities for improvement identified.** **5. Date of correction**	**6/4/15**