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	355089	A. BUILDING _____ B. WING _____	06/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PARK RIVER	301 COUNTY RD 12B PARK RIVER, ND 58270

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on June 25, 2012 and completed on June 28, 2012, the sample included 2 residents for complete review, 9 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	"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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State Law require it. For the purposes of any substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Center for Medicare and Medicaid.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to provide cares in a dignified manner for 2 of 11 sampled residents (Resident #1 and #2) and 1 supplemental resident (Resident #14). Failure to feed and provide personal cares in a dignified and respectful manner does not maintain or enhance the residents' dignity, self worth, or self esteem. Findings include: Review of the facility procedure titled "Resident Dignity" occurred on 06/28/12. This policy, dated April 2005, stated, ". . . Procedure: . . . Ideas for maintaining a resident's dignity may include, but not be limited to: . . . d. Promoting resident independence and dignity in dining. (Examples	F 241	1. Repeat education on dignity issues was provided. Residents #1 and #2 and #14 will have a napkin used to wipe their faces. Resident #1 curtains will be closed during personal cares. Telephone to Julie Skorheim DON 7/31/12 by - 3:00 pm AL 2. All residents have the potential to be at risk for failure to be treated in a dignified manner. 3. Mandatory education was provided on the procedure titled: Resident Dignity for nursing and activity staff on the proper dining assisting techniques including proper use	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joan Olson — TITLE: Administrator — (X6) DATE: 7-27-12

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 241	Continued From page 1 include avoidance of day to day use of bibs (also known as clothing protector instead of napkins . . .) . . . f. Respecting the resident's social status by speaking respectfully. . ." - On 06/25/12 at 5:40 p.m. in the dining room, observation showed a certified nurse aide (CNA) (#13) assisted Resident #1 to drink honey thickened liquids from a nosey-cup. The resident wore a clothing protector and the CNA used this clothing protector to wipe liquid residue from the resident's mouth/chin multiple times throughout the meal. The CNA failed to use the napkin lying next to the resident's place-setting to wipe her face. - On 06/25/12 at 5:58 p.m. in the dining room, observation showed a CNA (#12) assisted Resident #14 to drink pureed food from a cup. The resident wore a clothing protector and the CNA used this clothing protector to wipe food residue from the resident's mouth and chin multiple times throughout the meal. The CNA failed to use a napkin to wipe the resident's face. - On 06/27/12 at 7:30 a.m. in the dining room, observation showed a CNA (#14) assisted Resident #1 to drink honey thickened liquids from a nosey-cup. The CNA (#14) scraped the excess liquid from the resident's mouth/chin twice with the nosey-cup, and mixed it back in with the liquid in her cup. The CNA failed to use the napkin lying next to the resident's place-setting to wipe her face. - On 06/27/12 at 12:30 p.m. in the dining room, observation showed a CNA (#15) mixing the pureed food items together on Resident #2's	F 241	of napkins vs clothing protectors, the mixing of pureed foods, ensuring that all curtains are pulled before giving cares and making insensitive comments. 4. An audit tool will be created to monitor the dignity issues. The Director of Nursing, Dietary Manager, QA Coordinator or their designees will complete the audit 3 times weekly for 2 weeks and then monthly times three. The results of the audits will be reported to the QA committee for further recommendations. 5. Completed August 6, 2012	

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F 241	Continued From page 2 plate. She then assisted Resident #2 to eat the pureed foods from a spoon, and scraped the excess food from the resident's mouth/chin with the spoon. The CNA mixed the resident's food items prior to presenting them to her and failed to use the napkin lying next to the resident's place-setting to wipe her face. - On 06/27/12 at 1:20 p.m., observation showed Resident #1 sitting in her wheelchair looking out her open window. Two CNAs (#5 and #15) transferred Resident #1 via a Hoyer lift into her bed, which faced the window. Following the transfer, the two CNAs (#5 and #15) provided toileting cares. As the CNA (#5) provided pericares, Resident #1 began having a bowel movement. Using a frustrated tone of voice, the CNA (#15) stated, "Oh for God's sake," to which the resident responded, "Am I okay?" The CNAs (#5 and #15) failed to close the curtains prior to providing toileting cares and a CNA (#15) made an insensitive comment during pericares. During an interview on 06/28/12 at 10:30 a.m., an administrative nursing staff member (#3) confirmed staff failed to treat the residents in a dignified manner, stating "They know not to do that."	F 241		
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 accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246		

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F 246	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure reasonable accommodation of individual needs regarding positioning at the dining room table for 1 of 2 sampled residents (Resident #11) observed with an inappropriate table height during meals. Failure to provide a dining room table at an appropriate height to meet individual needs limited the resident's access to meal items and may have contributed to her weight loss, limited the quality of the dining experience, and may cause discomfort related to improper positioning. Findings include: Review of the facility policy titled "Dining Room Guidelines" occurred on 06/28/12. The policy, revised January 2012, stated: ". . . Purpose: . . . 6. For residents who must remain in their wheelchairs or other adaptive chairs, care should be taken to assure that each person is at an appropriate height and distance to the table and is in a functional position for self-eating. . . ." Observations in the dining room showed the following: * On 06/26/12 at 8:15 a.m. and 12:30 p.m. and on 06/27/12 at 5:30 p.m., Resident #11 sat in her low wheelchair at a dining room table. Resident #11 fed herself following tray set-up. She leaned forward to access the items on her plate, with her forearms on the table and her shoulders at a 90	F 246	1. Resident #11 was re-evaluated for table placement by Rehabilitation Nurse. The care plan was amended to residents request that she not be put into a dining room chair. 2. All residents eating in the dining room, have a low seat, and/or have weight loss have the potential to be affected. All residents on the nutritional at risk committee will have their table height assessed for appropriate height and documented in the IDPN. 3. Education provided to nursing and dietary staff on the procedure Dining room Guidelines with a focus on ensuring an appropriate table height during meals and care planning any individual resident preferences. 4. An audit will be created to monitor the dining room for appropriate table heights. The Rehabilitation Nurse, QA Coordinator or designee will be responsible for the completion of the audit according to the MDS schedule for 3 months, then quarterly times one. The results will be reported to the QA Committee for further recommendation. 5. Completed August 6, 2012.	

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degree angle to her body. The table was approximately three inches below her chin or at the level of her upper chest.
* On 06/28/12 at 7:50 a.m., Resident #11 sat in her wheelchair at a dining room table. Resident #11 fed herself following tray set-up. The lip of the resident's cereal bowl was at the level of her chin. Observation showed Resident #11 picked up her cereal bowl and held it between her body and the table to access her cereal.

Record review for Resident #11 occurred on June 27-28, 2012. Medical diagnoses included depression with anxiety. The annual Minimum Data Set (MDS), dated 03/26/12, identified moderate cognitive impairment and independence with eating with setup help only.

Resident #11's current care plan stated the following, ". . . Problems: . . . Alteration in nutrition . . . Approaches: . . . Regular, small servings . . ."

The "Interdisciplinary Assessments and Summary Reviews" identified the following notes by a licensed nurse:
* On 12/27/11, ". . . Table placement is all right - she is in a low w/c [wheelchair] - table is at lowest level. . . ."
* On 03/27/12, " . . . Table placement is good - her chair is low so table at lowest level. . . ."
* On 06/27/12, ". . . Intakes average 42% of meals . . . Table placement is as good as can be as has low w/c - Table is at lowest level. . . ."

During an interview on 06/28/12 at 9:00 a.m., when asked why Resident #11 was not placed at a lower table, a managerial dietary staff member (#10) stated, "That's as low as the table goes."

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F 246	Continued From page 5 When asked if the facility had attempted any other interventions, she stated, "No."	F 246	1. Bladder Assessments were completed for Residents #2, #8, and #9. Care plans updated with individualized toileting program. A correction was made to the MDS for Resident #9. Scheduled MDS's will be completed for Resident 2 & 8 before Aug 6, 12. per telephone conference with Lorie Skorheim DON 7/31/12 at 3PM. RL 2. A query was run to identify all residents having a bowel or bladder program scored on the Minimum Data Set (MDS) who have the potential to be affected. Bladder Assessments completed and Care plan update to reflect individualized toileting program. 3. A mandatory meeting for the nurse manager on the LTC facility RAI manual 4-12 pages H-5 and H-6 and review of GSS procedure titled Toileting plans will be completed. 4. An audit tool on monitoring individualized toileting plans and completed by the DNS, QA Coordinator or there designee. The audit will be completed according to the MDS schedule for three months, then quarterly times one month. The results of the audits will reported to the QA Committee for further recommendations. 5. Completed August 6, 2012	
F 278 SS=D	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. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/09/11.	F 278		

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Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to accurately complete the toileting section of the Minimum Data Set (MDS) for 3 of 3 sampled residents (Resident #2, #8 and #9) identified as being on a toileting program. Failure to accurately complete portions of the MDS for sampled residents does not allow each resident's comprehensive assessment to reflect care provided consistent with their individual needs and problems.

Findings include:

The Long-Term Care Facility RAI User's Manual, dated April 2012, pages H-5 and H-6, states "Toileting programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to simply tracking continence status . . . random assistance with toileting or hygiene." Requirements include "implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding pattern . . . notations of the resident's response to the toileting program and subsequent evaluations . . ."

- Review of Resident #8's medical record occurred on June 27-28, 2012. Diagnoses included overactive bladder and dementia with behavior disturbance. Resident #8's quarterly MDSs, dated 05/03/12 and 02/01/12, indicated

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moderately impaired cognition, extensive assistance of one person with toileting, current toileting plan, and occasional incontinence.

Resident #8's current care plan stated, "'Alteration in elimination . . . manifested by frequent incontinence. . . . Toilet per schedule or request with 1-2 assist stand lift. Toilet schedule: Noc, AM, PM, before and after meals and naps, before bed. . . . " The current bladder assessment, dated 04/14/11, showed ". . . daily incontinence . . . sometimes don't get to bathroom in time . . . may leak urine daily . . . Recommend for a Toileting Program: 'No' . . . Resident asks for assistance to toilet." The facility failed to establish an individualized toileting program based on the resident's voiding pattern.

During an interview on 06/27/12 at 5:10 p.m., a certified nurse aide (CNA) (#9) stated when questioned regarding Resident #8's toileting schedule, "She lets us know when she needs to go to the bathroom."

- Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia, depression, and diabetes. Resident #2's MDSs; dated 04/03/12, 01/02/12, 10/17/11, and 09/13/11, identified severe cognitive impairment, frequent urinary incontinence and on a scheduled toileting program.

Resident #2's current care plan stated the following, ". . . Problems . . . Episodes of bowel [and] bladder incontinence with some control present. . . Plans and Approaches . . . Toilet: Assist (1) [of one person] per schedule NOC

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[night], AM, PM, HS [bedtime] Before [and] after meals. . . ." The facility failed to establish an individualized toileting program based on Resident #2's voiding pattern.

Observation on 06/26/12 at 1:50 p.m., showed Resident #2 was incontinent prior to being placed on the toilet.

- Record review for Resident #9 occurred on June 27-28, 2012. Medical diagnoses included dementia, constipation, urinary incontinence, and history of urinary tract infections (UTIs). An annual MDS, dated 08/31/11, and the most recent quarterly MDS, dated 05/29/12, identified Resident #9 required extensive assistance of one person with toileting, on a current toileting program, and frequently incontinent of both bowel and bladder. The quarterly MDS identified Resident #9 with severe cognitive impairment.

Resident #9's current care plan stated, "Problems/needs/concerns. Episodes of bowel incontinence and urinary incontinence, hx [history] of UTI, forgetful. Long/short term goals. Will maintain present continence level . . . Plans and approaches. Toilet before brk [breakfast], midmorning, before dinner, before afternoon nap, before supper, and at bedtime. Toilet schedule cont. [continued]: NOC [night] 1st and 3rd rounds." The facility failed to establish an individualized toileting program based on the resident's voiding pattern.

Facility staff failed to assess each resident's voiding pattern, failed to develop an individualized, resident-specific toileting program, failed to assess each resident's response to the

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F 278	Continued From page 9 toileting program (other than tracking their continence/ incontinence status), failed to consider the appropriateness of the toileting programs, and failed to re-evaluate each toileting program periodically.	F 278		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to provide appropriate treatment and services to restore as much normal bladder function as possible for 1 of 1 sampled resident (Resident #3) identified with a urinary catheter. Failure to assess residents' toileting patterns, implement individualized toileting programs, and evaluate the programs for effectiveness does not allow residents to achieve their highest level of continence. Findings include: Review of the facility policy titled "Toileting Programs" occurred on 06/28/12. The policy,	F 315	1. Bladder Assessments were completed for resident #3. The care plan was updated to reflect changes. 2. All residents having catheters that have been removed have the potential to be affected. 3. A mandatory meeting for the nurse manager on the procedure titled Toileting plans 4. An audit tool on monitoring individualized toileting plans, and bladder assessment upon the removal of the catheter. The audit will be completed by the DNS, QA Coordinator or there designee. The audit will be completed monthly for three months. The results of the audits will reported to the QA Committee for further recommendations. 5. Completed August 6, 2012	

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revised January 2011, stated: ". . . Procedure . . . 4. The care plan should . . . include measurable goals to maintain or restore the highest level of continence possible for a resident. . . . It is also recommended that initially, based on the resident's response, weekly adjustments be made to the interventions and to increase time between voidings by 15 to 30 minutes. . . . 7. Some residents may not be candidates for a scheduled toileting program though this decision is based on the evaluation of the individual resident. . . . 9. Residents should be re-evaluated whenever there is a change in condition, physical ability, or urinary tract program (RAI Section H). . . ."

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included generalized muscle weakness, history of UTI, and history of urinary catheter. Resident #3's significant change MDS, dated 06/09/12, indicated intact cognition and occasionally incontinent of urine.

Resident #3's current bladder assessment, dated 01/25/12, indicated the resident as continent with a urinary catheter.

The monthly nursing documentation flowsheet, continence/incontinence section, dated 05/17/12, stated, "D/C [discontinue] Foley catheter 5/2/12. Incontinent of bowel et [and] bladder," and dated 06/17/12, stated, "Resident was incontinent of urine 30x's [times] et continent 22x in past week. . . ."

Resident #3's Care Area Assessment (CAA) for Urinary Incontinence, dated 06/14/12, stated, ". . .

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the resident needs assistance with toileting and she is frequently incontinent. . . . Due to overall improvement in condition, resident is able to toilet with the stand lift per schedule and request. Continence is improving. . . ."

Resident #3's current care plan stated, ". . . Alteration in bowel and bladder elimination r/t [related to] debilitated state m/b [manifested by] incontinence . . . Toilet per schedule with stand lift. Disposable undergarment: assist w/ [with] change & provide pericares as needed check Q [every] 2-3 hrs [hours] . . ."

During an interview on 06/27/12 at 4:25 p.m., a nursing supervisor (#11) when questioned on the definition of "Toilet per schedule" in Resident #3's care plan, stated, "We don't have a schedule in place yet." At 5:05 p.m., a certified nurse aide (CNA) (#9) stated, "We check on [Resident #3] about every 3 hours and try to get her to use the bathroom."

Observations showed the following:
* 06/26/12 at 7:45 a.m. - Incontinent in brief and voided on toilet
* 06/26/12 at 11:40 a.m. - Incontinent of stool
* 06/26/12 at 1:10 p.m. - Voided during transfer onto toilet and voided in toilet
* 06/26/12 at 3:50 p.m. - Brief checked and is dry, offered toilet and resident refused
* 06/26/12 at 4:54 p.m. - Incontinent of urine and voided on toilet

Failure to complete a bladder assessment after staff discontinued Resident #3's catheter, evaluate the effectiveness of the toileting program, and adapt the toileting program

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F 315	Continued From page 12 according to the resident's assessed continence status, may have contributed to Resident #3's incontinence, placed her at risk for UTIs, and has the potential to compromise her dignity.	F 315	1. Repeat education was provided to staff for Residents #6, #15, #16, #17, and #18 on proper use of assistive devices (gait belt, wheelchair brakes and/or foot pedals) and supervision reminders. 2. All residents have the potential to be affected. 3. Education was provided on the procedure titled, "Suggested Care plan approaches for Fall prevention" to nursing and activity staff with a focus on the use of gait belts, foot pedals, and assistive devices to reduce the risk of falls and providing supervision as necessary. 4. An audit will be created to monitor proper use of gait belts, wheelchair brakes, and foot pedals. The Restorative nurse, DNS, QA Coordinator or their designee will complete the audit three times a week for two weeks, then weekly for 4 weeks. The results of the audits will be reported to the QA Committee for further recommendations. 5. Completed August 6, 2012	
F 323 SS=E	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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/09/11. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure all residents received adequate supervision and assistive devices to prevent accidents for 1 of 4 residents (Resident #6) with a history of falls and 4 supplemental residents (Resident #15, #16, #17, and #18) observed being transported by staff via wheelchairs with no foot pedals. Failure of the facility staff to ensure proper use of assistive devices (gaitbelt, wheelchair brakes and/or foot pedals) places residents at risk for possible accidents and/or injuries. Findings include: Review of a facility document titled, "Suggested	F 323		

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Care Plan Approaches for Fall Prevention," occurred on 06/28/12. This document, revised September 2010, stated, ". . . Ensure that wheel chair and bed wheels are locked. . . . Assist resident with transfer and ambulation using a gait belt. . . . Assist resident to bathroom as appropriate. Do not leave resident unattended in bathroom unless resident is able to reliably use the call light . . . Remind resident not to stand/transfer without assistance. Consider use of adaptive equipment as indicated. . . ."

Review of the facility policy titled "Restorative Nursing Programs - ROM [range of motion] and Ambulation Wheelchair Positioning" occurred on 06/28/12. The policy, revised January 2011, stated: ". . . Correct Wheelchair Positioning . . . Feet are flat on the foot pedals . . ."

- Record review for Resident #6 occurred on all days of survey. Medical diagnoses included history of falls, generalized weakness, blindness, hearing loss, and pain. The admission Minimum Data Set (MDS), dated 11/30/11, identified the resident sustained a fall prior to admission. The quarterly MDS, dated 02/16/12, identified the resident fell one time with no injury. The quarterly MDS, dated 05/18/12, identified the resident fell three times: two times with no injury and once with an injury, and had short-term memory problem and moderate cognitive impairment. All three MDSs identified Resident #6 required extensive assistance of one person with transfers. Further review of the record identified the resident fell a total of six times since admission due to either self-transferring or weakness during transfer with assistance.

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F 323	Continued From page 14 The "Fall Data Collection Tool," completed on 11/21/11, 02/16/12, 03/21/12, and 04/21/12 identified total scores of 24, 24, 24, and 26, indicating a high risk for falls. The current comprehensive care plan stated, "Mobility deficit R/T [related to] blindness, HOH [hard of hearing] . . . Hx [history] & [and] risk for falls. . . . Transfer: Pivot transfer or stand lift, edge defining mattress . . . bed alarm . . . toilet: assist of 1 . . ." Observation of transfers/toileting for Resident #6 identified the following: * 06/26/12 at 9:05 a.m. - A certified nurse assistant (CNA) (#4) transferred Resident #6 to bed from her wheelchair using a gait belt. Observation showed the gaitbelt loose around the resident's waist. During the transfer, the gaitbelt shifted upward toward the resident's upper back. Observation showed the resident became weak and sat down on the edge of the bed. The CNA needed to reposition the resident to prevent her from sliding onto the floor. * 06/26/12 at 1:10 p.m. - A CNA (#4) transferred Resident #6 from the toilet to her wheelchair. The CNA applied a gait belt around the resident's waist and tightened it. The CNA did not lock the brakes on the wheelchair. During the transfer, the wheelchair rolled backward causing the resident to sit on the very edge of the wheelchair. The resident required repositioning in the wheelchair to avoid sliding out of the wheelchair. * 06/27/12 at 9:40 a.m. - A CNA (#4) assisted Resident #6 to the bathroom. The CNA left the	F 323		

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room and returned a few minutes later when Resident #6 turned her bathroom light on. Upon entering the bathroom, observation showed Resident #6 standing up from the toilet on her own and attempting to transfer herself into her wheelchair. The CNA prompted the resident to sit back down on the toilet. While leaving the bathroom to obtain gloves, the CNA stated "I told her I would be right back." The CNA then assisted the resident with hygiene cares and transferred the resident to her wheelchair. During the observation, the CNA failed to remind the resident not to attempt to transfer on her own.

After the observation, the CNA (#4) stated Resident #6 is "forgetful" and needs prompting at times.

During an interview on the morning of 06/28/12, an administrative nurse (#3) confirmed the resident is forgetful, blind, and hard of hearing, placing her at risk of falls. She further acknowledged the safety risk of improper gaitbelt use, failure to utilize the brakes on the resident's wheelchair, and self transferring when left alone in the bathroom.

Failure of the facility to assess Resident #6 for appropriate interventions to prevent falls, such as assistive devices and supervision/reminders, as stated in their policy placed Resident #6 at risk of continued falls.

- Resident #15's medical record, reviewed June 25-28, 2012, identified diagnoses including joint pain and history of right pelvic fracture. The resident's quarterly MDS, dated 04/12/12, identified extensive assistance of one person

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F 323	Continued From page 16 required for locomotion on unit and limited assistance of one person required for locomotion off unit. Observation on 06/27/12 at 5:25 p.m. showed a CNA (#6) transporting Resident #15 in her wheelchair down the hallway towards the dining room. Observation on 06/28/12 at 8:00 a.m. also showed a restorative nursing assistant (#7) transporting Resident #15 in her wheelchair down the hallway towards the dining room. During both observations, Resident #15's feet/shoes caught and bounced on the transition strip as staff transported her into the dining room. - Resident #16's medical record, reviewed June 25-28, 2012, identified diagnoses including dementia and pain. The resident's quarterly MDS, dated 03/26/12, identified limited assistance of one person required for locomotion on/off unit. Observation on 06/27/12 at 10:45 a.m. showed a CNA (#6) transporting Resident #16 in her wheelchair down the hallway towards the dining room. Resident #16's feet/shoes made an audible noise as they came in full contact with the carpeting and/or linoleum as staff transported her into the dining room. - Resident #17's medical record, reviewed June 25-28, 2012, identified diagnoses including spinal stenosis, back pain, and muscle weakness. The resident's admission MDS, dated 04/03/12, identified total assistance of one person required for locomotion on/off unit. Observation on 06/28/12 at 8:00 a.m. showed an unidentified CNA transporting Resident #17 in her	F 323		

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F 323	Continued From page 17 wheelchair down the hallway towards the dining room. Resident #17's feet/shoes slid along the surface of the carpeting and/or linoleum as staff transported her into the dining room. - Resident #18's medical record, reviewed June 25-28, 2012, identified diagnoses including confusion, Parkinson's disease, spinal stenosis, back pain, and history of lumbar vertebra fracture. The resident's admission MDS, dated 05/09/12, identified extensive assistance of one person required for locomotion on/off unit. Observation on 06/28/12 at 10:50 a.m. showed a social services staff member (#8) transporting Resident #18 in his wheelchair down the hallway towards the dining room. Resident #18's feet/shoes initially caught and bounced on the carpeting, bringing the wheelchair to a stop. The social services staff member (#8) stated, "Oh my, sorry." She then cued the resident to lift his feet and resumed transporting him down the hallway. Staff members failed to place the residents' foot pedals on their wheelchairs, cue the residents to lift their feet/shoes, and ensure the residents' feet/shoes cleared the floor during transport to avoid catching the residents' feet on the flooring. During an interview on 06/28/12 at 10:30 a.m., an administrative nursing staff member (#3) agreed staff should have utilized assistive devices (wheelchair foot pedals) during transport.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a	F 325		

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F 325	Continued From page 18 resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure acceptable parameters of nutritional status for 3 of 5 sampled residents (Resident #6, #9, #11) who experienced unplanned weight loss. Failure to implement additional interventions or evaluate the effectiveness of current interventions may have contributed to Resident #6's continued weight loss and placed Resident #9 and #11 at ongoing nutritional risk. Findings include: Review of facility policies occurred on June 27-28, 2012. A facility policy titled "Nutrition Care: Residents with Impaired Nutrition and Nutritional Risk," revised September 2009, stated, "Purpose: To identify residents with impaired nutrition or at nutritional risk . . . Procedure . . . 3. The director of dietary services (DDS)/registered dietician (RD) will identify residents with impaired nutrition or at nutritional risk such as: a. BMI < 19 or low weight for usual body weight b. Meal or fluid intake less than 75 percent at most meals	F 325	1. Registered Dietician evaluated Residents #6, #9, and #11 for effectiveness of care plan nutritional interventions. Their care plans were updated with the additional nutritional interventions. 2. MDS query of section K0300 and K 0310 is coded as a 2 (wt. loss or wt. gain, not on physician weight loss or weight gain regimen. The residents that trigger will be reviewed by the RD. 3. Education will be provided to nursing and dietary staff on the documentation of nutrients and supplements. The reviewed and amended the Procedure "Residents with Impaired Nutrition and Nutritional Risk" to include individualizing caloric needs based on the assessment of the residents' estimated nutritional needs.	

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F 325	Continued From page 19 c. Consistent decline in meal/fluid intake d. Insidious weight loss/gain 4. The DDS or designee will review resident weights monthly or more often to identify residents with significant weight loss/gain (5 percent in 30 days, 7.5 percent in 90 days or 10 percent in 180 days) or insidious weight loss or gain. Insidious weight loss or gain refers to a gradual unintended, progressive weight loss or gain over time. 5. The DDS will maintain a list of residents with impaired nutrition or at nutrition risk. These residents will be discussed at the next nutritional risk committee meeting at least monthly and will be reviewed by the registered dietitian. 6. The DDS will telephone the RD to inform of residents newly identified with impaired nutrition or at nutrition risk. 7. The DDS will make a note in the medical record . . . that the RD was notified and any immediate measures that will be put in place per the RD." A facility policy titled "Nutrition Care: Interventions for Nutritional Risk of Residents," revised March 2009, stated, "Purpose: To provide staff guidelines for interventions for residents at risk of nutritional decline. . . . 5. Interventions will be added to the care plan. Interventions may include but are not limited to: . . . Monitor supplements/snacks on the Nourishment/Supplement intake record . . . Snacks between meals . . . " - Record review for Resident #6 occurred on all days of survey. Medical diagnoses included: anemia, generalized weakness, constipation, anxiety, and blindness. The most recent Minimum	F 325	4. An audit tool will be developed to monitor nutritional interventions, their effectiveness and documentation. The Dietary Manager, QA Coordinator or their designees will be responsible for the completion of the audit weekly for four weeks, then monthly for 2 months. The results of the audits will be reported to the QA committee for further recommendations. 5. Completed August 6, 2012.	

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Data Set (MDS), dated 05/18/12, identified short term memory problems, extensive assistance with eating, and weight loss not physician prescribed.

Review of Resident # 6's "Weight Report/Variance report" from 12/02/11 with a weight of 123 pounds (#) through 06/05/12 with a weight of 105# identified a loss of 18 pounds or 14 percent (%), a severe weight loss of greater than 10% in six months

The current comprehensive care plan stated: "Problems/needs/concerns. Alteration in nutrition R/T [related to] blindness both eyes, . . .
Long/Short term goals. Resident will eat > 75% of meals, eat independently, maintain weight . . .
Plans and Approaches.. . . assisted table: cueing and encouragement. . . . monitor weight . . ."

Resident #6's Initial "Nutrition Assessment," dated 01/12/12, identified a weight of 120.0, a Body Mass Index (BMI) of 21.25 and a weight goal of "maintenance."

A dietary summary, dated 01/12/12, stated, ". . . current weight 120#. BMI 21.25. . . . Goals are for her to maintain her wt. [weight] between 120-125#. Maintain intakes > 75% et [and] encourage [increased] pro [protein] items d/t [due to] anemia."

Review of Resident #6's dietary progress notes identified the following:
* 04/26/12 - ". . . has lost 14# since 11/11 from 124# TO 110#, which is a 11.29% Wt. loss. Her appetite has been poor with intakes < 75%. . . . enjoys ice cream shakes in between meals et

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Resource Breeze [protein supplement] [with] breakfast meal. Will continue to monitor via N. Risk. [nutritional risk.]"
* 05/23/12 - "N. Risk. . . . wt. is 106# which is a 4# loss in 30 days. She has been refusing to eat, her intakes averaging 52%. A psych referral has been requested. She does enjoy coffee so I would recommend adding protein powder in her coffee. . . . Will continue to monitor via N. Risk."
* 06/20/12 - "N. Risk. wt. is [down] slightly to 104#. . . . has had better intakes et is not as agitated . . . Will DC [discontinue] N. Risk."

Review of Resident #6's "Dining Record," from 06/15/12 through 06/27/12 identified meal intakes ranging from 0-75% and no evidence of nourishment [snack] or supplement intake.

During an interview on 06/27/12 at 7:50 a.m., an managerial staff member (#10) stated Resident #6 "has eaten well this week" but this is not "always typical." This staff member stated the facility tried Resource juice, but Resident #6 did not like it and would not drink protein powder in her coffee. When asked what else the facility has tried, this staff member stated Resident #6 receives snacks between meals, like cookies and ice cream, and will take them when offered. During a follow-up interview at 10:30 a.m., the administrative dietary staff member (#10) stated the term "nourishment" on the dining records refers to snacks and any intakes would be charted here. She stated staff do not always document snack intake depending on who is working, and she acknowledged this is a problem. She stated snacks should be offered and any refusals should be charted.

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F 325	Continued From page 22 Observation of Resident #6 throughout the survey showed no snacks or supplements offered between meals. Observation of lunch on 06/26/12 at 12:20 p.m. showed Resident #6 offered and consumed ice cream with her meal; however, observation showed ice cream offered and available to all residents and not specifically as an additional intervention for the resident's weight loss. Review of the "Nourishment/Supplement," list updated on 06/28/12, showed Resident #6 not on the list to receive a snack or supplement between meals. During a follow-up interview on 06/27/12 at 2:20 p.m., the managerial dietary staff member (#10) stated Resident #6 does not usually refuse snacks. This staff member stated Resident #6 is not currently on the "nutritional risk" list, but acknowledged she "probably should be." - Record review of Resident #9 occurred on June 27-28, 2012. Medical diagnoses included dementia, constipation, and anemia. The annual MDS, dated 08/31/11, and the quarterly MDS, dated 05/29/12, identified extensive assistance with eating and weight loss not physician prescribed. The quarterly MDS identified severe cognitive impairment. Review of Resident #9's diet card on the morning of 06/28/12 showed 4 oz. of 'half and half" as additional calories at breakfast. Review of Resident #9's "Weight Report," from 02/14/12 through 06/28/12 showed a 5% weight loss from April 26, 2012-May 24, 2012 (100# to	F 325		

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F 325	Continued From page 23 95#). Review of the "Nourishment/Supplement," list updated on 06/28/12, showed Resident #9 not on the list to receive a snack or supplement between meals. Review of the "Interdisciplinary Assessments and Summary Reviews" identified the following: * 02/28/12 - ". . . Current weight is 100#, over last 180 days ranging from 92#-100#. Did have her on a supplement but she really refused it . . . changed to PRN [as needed] status so we may try to add it again to her diet if weight decreases. . . ." * 05/31/12 - ". . . At times she will refuse meals. . . . Not doing as well as last quarter as far as eating et appetite . . . Current wt. 95# ([down] 5% in 30 days) but not at her lowest wt. Doesn't want supplement. Will continue to monitor for any more weight loss. . . ." Review of Resident #9's current comprehensive care plan stated, "Problems/needs/concerns. Alteration in nutrition R/T anemia, weakness, . . . plans and approaches . . . supplement: 4 oz. [ounces] prn or as she desires . . . may have toast or sandwich at NOC [night] on occ. [occasion]. . . . monitor weight . . ." During an interview on the morning of June 28, 2012, an managerial dietary staff member (#10) stated staff discontinued Resident #9's sandwich at night due to "hoarding food" and not eating the sandwich. This staff member did not identify additional interventions the facility implemented to address her weight loss.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355089	A. BUILDING _____ B. WING _____	06/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PARK RIVER	301 COUNTY RD 12B PARK RIVER, ND 58270

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F 325	Continued From page 24 The care plan lacked any additional interventions to address Resident #9's weight loss (snacks between meals, high calorie foods at meals, etc). The facility failed to address Resident #6 and #9's weight loss according to facility policies and procedures, failed to develop a comprehensive care plan with specific interventions, failed to consistently document and monitor intake between meals, and failed to prevent significant weight loss to both residents. - Record review for Resident #11 occurred on June 27-28, 2012. Medical diagnoses included depression with anxiety. The annual MDS, dated 03/26/12, identified moderate cognitive impairment and independent, after setup help, with eating. The "Consultant's Progress Note," dated 08/23/11, stated, "DC'd [discontinued] from N. [nutritional] risk. [Resident #11's] wt [weight] has stabilized along [with] intakes." The "Nutrition Assessment," dated 03/22/12, stated, ". . . Meal intakes average 66%. . . ." The "Interdisciplinary Assessments and Summary Reviews," dated 06/27/12, stated, ". . . Intakes average 42% of meals . . ." The "Weight Report," dated 12/25/11-06/27/12, showed Resident #11 had a 7.9% weight loss between 12/29/11- 06/21/12, dropping from 101# to 93# within 6 months. Resident #11's current care plan stated the following, ". . . Problems: . . . Alteration in nutrition	F 325		

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F 325	Continued From page 25	F 325		

r/t [related to] small appetite . . . Goals: Resident will eat > [greater than] 75% of meals maintain weight . . . Approaches: . . . Regular, small servings, 1/2 [half] and 1/2 [at] brkfst [breakfast] for cereal, 4 oz [ounces] high calorie high protein supplement prn . . . monitor weight . . ." Resident #11's diet card also showed "4 oz 1/2 [and] 1/2" served in the mornings.

The "Fax Communication with Physician" note, dated 05/16/11, stated, "May we change order to read 4 oz high calorie high protein supplement prn. Resident has been refusing supplement."

The "H.S. Nourishment/Supplements" list, updated 06/28/12, showed staff offer Resident #11 4 oz of plain chocolate milk in the evenings.

During an interview on 06/28/12 at 9:00 a.m., when asked why Resident #11 was not placed on the nutritional risk list and monitored more closely, a managerial dietary staff member (#10) stated, "We just identified that (42% intake at meals). She'll go on the nutritional risk list next month at our next meeting." The managerial dietary staff member (#10) did not respond when asked why Resident #11 was not placed on the nutritional risk list in March 2012, when her intake fell below the 75% standard identified in the facility's policy.

Failure to evaluate the effectiveness of current interventions and implement additional interventions contributed to Resident #11's gradual, unintended weight loss.