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 _____	07/18/2013

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

(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 07/15/13 and completed on 07/18/13, the sample included two (2) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review. The sample included three (3) 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 272 SS=B	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;	F 272	F272 1. MDS assessments were reviewed for resident #8 and #12 with no change. 2. All resident's have the potential to be affected. By receiving additional education all residents will have accurate MDS assessments. 3. Nursing management team reviewed MDS item Z0500 procedure and attended a training workshop on August 6 and 7, 2013 presented by the Good Samaritan Society National Campus Reimbursement staff.	

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

Joan Olson | Administrator | 8-16-13

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.

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 _____	07/18/2013

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

(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 272	Continued From page 1 Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), and staff interview, the facility failed to use the entire required days of observation when completing the Minimum Data Sets (MDSs) on 1 of 11 sampled residents (Resident #8) and one closed record (Resident #12). Failure to collect assessment information for the entire required observation period may result in an incomplete and/or inaccurate assessment of the resident's performance and health status. Findings include: The Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), page A-23 and Z-8 state, ". . . As the last day of the look-back period, the ARD [Assessment Reference Date] serves as the reference point for determining the care and services captured on the MDS assessment . . . For example, the MDS item with a 7-day look-back period ending on and including the ARD which is the 7th day of this look-back period	F 272	4. The DNS or designee will be responsible for the completion of the MDS audits that will be performed on random residents one time per week for 4 weeks, then one time per month times 3 months and then as deemed necessary by the Quality Assurance Committee. 5. Completed August 22,2013	

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 _____	07/18/2013

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

(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 272	Continued From page 2 . . . The look-back period includes observations and events through the end of the day (midnight) of the ARD . . . For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as completed by the RN [Registered Nurse] assessment coordinator . . ." - Record review for Resident #8, and #12 occurred between July 15-18, 2013. Review of these records revealed the facility staff failed to collect MDS assessment information on the last day of the assessment period, as the RN Assessment Coordinators signed and dated each assessment as completed on the last observation day (the ARD) prior to midnight. The MDSs identified the following: * Resident #8 - annual assessment - ARD and Z0500B date of 12/06/12 * Resident #8 - quarterly assessment - ARD and Z0500B date of 06/06/13 * Resident #12 - annual assessment - ARD and Z0500B date of 03/26/13 On 07/18/13 at 11:40, two administrative nurse staff members (#2 and #3) confirmed the facility failed to collect MDS assessment information on the last day of the assessment period, as the RN Assessment Coordinators signed and dated the above assessments as completed prior to midnight on the last observation day.	F 272		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278		

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 _____	07/18/2013

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

(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 278	Continued From page 3 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 jUNE 28, 2012. Based on observation, record review, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to implement an individualized, resident-specific program based on an assessment of the residents' unique voiding patterns for 4 of 6 sampled residents (Resident #1, #2, #3, and #11) coded on the Minimum Data Set (MDS) as having a toileting and/or bowel program in place and failed to code	F 278	F278 1. Residents #1, #2 and #11 were evaluated as per MDS assessment. Resident #2's MDS was corrected on July 22, 2013 to remove IV fluids from the MDS information. Annual MDSs were completed on resident #1 on July 17, 2013 and on resident #11 on July 20, 2013. Resident #3 discharged on July 22, 2013. Coding changes did not result in classification changes. 2. An MDS query to review appropriateness of coding will be run to identify other residents scored with a bowel and/or bladder program and scored with IV fluids on the MDS. The results of these queries will be evaluated to determine if any other residents were affected. 3. Nursing management reviewed the RAI procedure for coding bowel and/or bladder programs and IV fluid and received additional education from the Good Samaritan Society National Campus Reimbursement staff on August 6 and 7, 2013. 4. An MDS audit of resident assessments and coding will be completed by the DNS or	

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 _____	07/18/2013

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

(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 278	Continued From page 4 the MDS correctly for 1 of 1 sampled resident (Resident #2) coded for receiving intravenous (IV) nutrition in the facility. Failure to implement individualized, resident-specific toileting programs based on assessments does not meet the requirement for coding a scheduled toileting program on the MDS. Failure to code MDSs correctly related to IV nutrition does not provide an accurate assessment of a resident's needs. Findings include: The Long-Term Care Facility RAI User's Manual Version 3.0, May 2013, stated the following: * Page H-6 (Urinary Toileting Program), stated, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated . . . A toileting program does not refer to: -simply tracking continence status, -changing pads or wet garments, and -random assistance with toileting or hygiene . . ." * Page H-12 (Bowel Training Program), stated the resident's medical record must include three requirement for a bowel toileting program, ". . . implementation of an individualized, resident specific bowel toileting program based on an assessment of the resident's unique bowel pattern; evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, verbal and a written report; and notations of the resident's response to the toileting program and subsequent evaluations, as needed." * Page K-11 (Nutritional Approaches), stated, ". . . Coding Instructions for Column 2 - Check all nutritional approaches performed after admission/entry or reentry to the facility and within	F 278	designee on one random resident per week times 1 month from the query list above or randomly from the MDS schedule. Then one time monthly times three months. The results of the audit will be reported to the Quality Assurance committee for additional recommendations. 5. August 22, 2013	

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 _____	07/18/2013

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

(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 278	Continued From page 5 the 7-day look-back period. . . ." * Page Z-6 stated, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for the development of: - an individualized care plan - The Medicare Prospective Payment System - Medicaid reimbursement programs - quality monitoring activities . . . - the data-driven survey and certification process - the quality measures used for public reporting . . ." - Review of Resident #3's medical record occurred on all days of survey. The quarterly MDS, dated 06/16/13, identified the resident as frequently incontinent of bowel and bladder and on urinary and bowel toileting programs. Resident #3's bladder assessment, dated 08/06/12, identified the toileting schedule, "Before breakfast 7:30-8:30, before lunch 10:30-11:30, Before afternoon nap 12:30-1:30, Before supper 4-5, and at HS [bedtime] 6:30-7:30, and prn [as needed]/per request." The bowel assessment, dated 08/06/12, stated "see bladder plan" as the toileting plan. Review of the "7 Day Observation Period" record, dated June 10-16, 2013, identified Resident #3 as incontinent of urine 35 times, continent of urine 12 times, incontinent of bowel 4 times, and continent of bowel 3 times. Observation on 07/15/13 at 4:45 p.m., 07/16/13 at 8:34 a.m., and 07/16/13 at 5:30 p.m., showed Resident #3's brief wet with urine when facility staff assisted her to the bathroom. Observation on 07/16/13 from 12:00 p.m. to 5:30 p.m. showed facility staff failed to assist Resident	F 278		

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 _____	07/18/2013

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

(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 278	Continued From page 6 #3 to the bathroom. Resident #3's medical record lacked evidence staff developed an individualized, resident-specific plan based on the resident's bowel and bladder patterns and/or evaluated the plan as identified in the RAI Manual as requirements for coding bowel and bladder toileting programs. - Review of Resident #11's medical record occurred on July 17-18, 2013. The quarterly MDS, dated 04/20/13, identified the resident as cognitively intact, frequently incontinent of urine, and on a urinary training program. Resident #11's bladder assessment, dated 11/14/12, stated, "Toilet on arising at 7am - 8am, & [and] 9:30am - 10:30am, after dinner 1 - 2 pm, after nap 3 to 4pm, and bedtime 8 - 9pm, per req [request] at noc [night]." During an interview on 07/17/13 at 12:55 p.m. and at 3:10 p.m., two CNAs (#8 and #13) stated Resident #11 informs the staff when she needs to use the bathroom. The CNA (#13) stated facility staff check her for incontinence every few hours during the night. During an interview on 07/18/13 at 9:00 a.m., Resident #11 stated she puts her call light on when she needs to use the bathroom and at night the staff check and change her brief if necessary. Resident #11's medical record lacked evidence staff developed an individualized, resident-specific plan based on the resident's urinary patterns and/or evaluated the plan as identified in the RAI Manual as requirements for	F 278		

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 _____	07/18/2013

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

(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 278	Continued From page 7 coding a bladder toileting program. - Review of Resident #1's medical record occurred July 15-18, 2013. A quarterly MDS, dated 04/17/13, identified the resident as on a bowel toileting schedule and usually continent of bowel. Resident #1's current care plan stated, "Resident is usually continent of bowel and bladder . . . Toilets with assistance per schedule wears pull up 7:00 - 8:00, 10:30 - 11:30, 12:30 - 13:30 [1:30 p.m.] 1630 - 1730 [4:30 to 5:30 p.m.]" Resident #1's medical record lacked evidence staff developed an individualized, resident-specific plan based on the resident's bowel pattern and/or evaluated the plan as identified in the RAI Manual as requirements for coding a bowel toileting program. - Review of Resident #2's medical record occurred July 15-18, 2013 and identified a hospitalization from June 15, 2013 to June 19, 2013 for a urinary tract infection. A quarterly MDS, dated 06/23/13, identified the resident as frequently incontinent of bowel, on a bowel toileting schedule, and received parenteral/IV feeding while a resident in the facility. Resident #2's current care plan stated, "Alternation in eliminations . . . increased incontinence of bowel and bladder . . . Toileting schedule: 0730-0830 [a.m.], 1000-1100 [a.m.], 1330-1430 [1:30 to 2:30 p.m.], 1630-1730 [4:30 to 5:30 p.m.], 2000-2100 [8:00 to 9:00 p.m.], and as needed/request." Resident #2's medical record lacked evidence staff developed an individualized, resident-specific plan based on the resident's	F 278		

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 _____	07/18/2013

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

(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 278	Continued From page 8 bowel pattern and/or evaluated the plan as identified in the RAI Manual as requirements for coding a bowel toileting program. The record failed to identify the administration of IV nutrition after Resident #2 returned from the hospital. During an interview on the afternoon of 07/17/13, an administrative nurse (#3) and two supervisory nurses (#1 and #2) stated an assessment of a resident's bowel and/or bladder toileting program included interviews with the direct care staff to see if they assisted the residents to the bathroom. During an interview on 07/18/13, an administrative staff member (#4) confirmed Resident #2 did not receive IV nutrition upon return from the hospital.	F 278		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, record review, and staff interview, the facility failed to ensure residents received the necessary services to maintain good nutrition for 1 of 4 sampled residents (Resident #6) and 1 supplemental resident (Resident #14) who required staff assistance with eating. Failure to provide residents with physical assistance during meals, including positioning to improve intake, may result	F 312		

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 _____	07/18/2013

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

(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 312	Continued From page 9 in decreased intake and weight loss. Findings include: Review of the facility policy titled "Resident-Assisted Dining" occurred on 07/18/13. This policy, revised November 2009, stated, ". . . 5. Encourage resident in feeding self, assisting as needed, following care plan approaches. . . ." Review of the facility policy titled "Dining Room Service" occurred on 07/18/13. This policy, revised November 2009, stated, ". . . 2. Assist resident to the table as per their individual needs. Encourage use of dining room chair versus wheelchair . . . 7. Encourage adequate fluids, get second helpings, and wipe up any spills as needed. Offer food alternatives for items not consumed. 8. If dining assistance is needed by a resident, staff are to sit next to the resident; do not stand and feed resident. Staff can assist two residents and offer assistance as needed. . . ." - Review of Resident #6's medical record occurred on all days of survey and diagnoses included history of dehydration, arthritis, weakness, kyphosis, and dementia. The admission Minimum Data Set (MDS), dated 05/21/13, identified severely impaired cognition and required extensive assistance of one staff member for eating. The current care plan stated, "Problem: . . . Alteration in nutrition R/T [related to] ulcer, H/O [history of] anorexia, decreased appetite . . . Approaches: . . . Regular, small portions with nutritional supplement 5x [times]/ [per] day . . . For all meals [and] snack time in DR [dining room] please transfer to a DR chair . . . Adaptive equipment: lip plate, blue mat. . . ."	F 312	F312 1. Residents #6 and #14 were referred to Occupational Therapist for screens with further recommendations given. Care plans for #6 and #14 updated accordingly. Resident #14 has been reviewed for positioning on several occasions with her specific requests honored. 2. Observed all residents while at the table to identify those that need positioning or physical assistance with meals. 3. Occupational Therapy will observe all residents while at the table during a meal for possible need of physical assistance during the meal and for positioning concerns. Nursing and dietary staff were educated on "Resident Assisted Dining" and "Dining Room Service" procedures. An inservice was given by the Altru Therapy Department to nursing and dietary staff on positioning and offering assistance at meals. 4. Audits will be performed weekly for 4 weeks, then monthly for one quarter, then as deemed necessary by the Quality Assurance committee. Responsible persons include: Both trainings will occur on 08/20/2013. per Julie Skorheim, DON 8/19/13 at 1140 CDeeper, RN	

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 _____	07/18/2013

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

(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 312	Continued From page 10 Observations occurred during the evening meal on 07/15/13, during all three meals on 07/16/13, and during breakfast and lunch on 07/17/13. These observations identified Resident #6 sat in her wheelchair, leaning back and to the right, with the wheelchair positioned away from the table, resulting in the resident reaching for each food and drink item. The resident ate the majority of her food with her hands, and when she attempted to use silverware, her arms and hands shook with a fine tremor, resulting in food falling off the utensil. Observation showed food on the floor, on the resident's clothing protector, and in the resident's lap and wheelchair. During the above observations, staff failed to ensure Resident #6 sat in a dining room chair, placed all of her food and drinks within reach, reposition her during the meals when she leaned, and offer/provide her with continued physical assistance during meals. During the evening meal on 07/17/13, Resident #6 sat in a dining room chair. When asked if she preferred sitting in the dining room chair versus her wheelchair during meals, the resident stated, "I like it. It is easier on my back - straighter." During an interview on 07/18/13 at 8:50 a.m., a dietary staff member (#4) stated Resident #6 requested to be transferred to a dining room chair for meals, which allows her to sit closer to the table, and stated she expected staff to do so for each meal and for snacks as care planned. On 07/18/13 at 9:45 a.m., an administrative nurse (#1) stated she expected staff to follow Resident #6's care plan and transfer her to a dining room chair for meals and snacks.	F 312	Dietary Manager, DNS, and others as designated. 5. Completed August 22,2013	

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 _____	07/18/2013

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

(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 312	Continued From page 11 - Review of Resident #14's medical record occurred on 07/18/13 and identified diagnoses of arthritis and dementia. The quarterly MDS, dated 04/19/13, identified the resident required extensive assistance of one staff member for eating. The current care plan stated, "Problem: Alteration in nutrition R/T anemia, weakness . . . SM [small] appetite H/O weight loss . . . Approaches: . . . Regular [diet], ground meat, small servings . . . adaptive equipment: lip plate, thermo mug with lid (dislikes lid may remove at times) . . . Assisted table may need assistance at meals but often refuses . . . may use her lap for food, if wishes. . . ." Observations during the noon and evening meals on 07/17/13 and showed Resident #14 sat in her wheelchair, away from the dining room table, and leaned significantly to the left with her head down. The resident had to reach for each food and drink item on the table and observation showed food on the floor, on the resident's face, and on her lap. Staff offered to assist Resident #14 with eating, which the resident declined, however, staff failed to reposition the resident in her wheelchair and failed to push the wheelchair closer to the table, which may have improved her ability to eat. During an interview on 07/18/13 at 8:50 a.m., a dietary staff member (#4) stated Resident #14 prefers to eat independently and stated the facility tried a smaller overbed table at meals in order for the resident to get closer to the table and her food items, but the resident did not like eating on that table. The staff member (#4) stated Resident #14 "always" leans to the left.	F 312		

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 _____	07/18/2013

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

(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 312	Continued From page 12 On 07/18/13 at 12:20 p.m., an administrative nurse (#1) stated the facility has not tried anything specific to correct Resident #14's leaning, other than reposition her when they see her leaning.	F 312		
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 COMPETED ON JUNE 28, 2012. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 6 of 10 sampled residents (Resident #1, #3, #5, #7, #8, and #9) and one supplemental resident (Resident #15) observed transferred with/or without a gait belt, walker, a sit to stand lift, and/or a full body lift. Failure to properly use a gait belt, a sit to stand lift, and a full body mechanical lift placed the residents at risk for sustaining a fall and/or injury. Findings include: Review of the facility policy titled "Gait (Transfer) Belt" occurred on 07/18/13. This policy, dated January 2009, stated, "Purpose *To safely	F 323	F323 1. Residents #1, #7, #9 and 15 were assessed for proper transfer assist. Care plans updated as needed. Individual education was provided to the staff at that time. Resident #3 discharged on July 22, 2013. Residents #5 and #8 discharged on July 19, 2013. 2. A query was run to identify all residents needing limited or greater assist with transfers that could be affected. 3. Education for the nursing department was held on August 20, 2013 by the EZ Way Company Representative and the Altru therapist. Education was given on procedures for gait belt transfers and lift transfers. 4. Audits of transfer assistance will be done per one time per week times four weeks on a random resident according to the MDS schedule. Then quarterly times 2 quarters. Responsible persons include: Rehabilitation Coordinator, Quality Assurance Coordinator and others as designated. 5. Completed August 22, 2013	

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 _____	07/18/2013

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

(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 13 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. . . . 5. When holding the belt an underhand grasp should be used. 6. Transfer or ambulate resident and remove belt." Review of the facility's instructions for the use of the sit to stand lift occurred on 07/18/13. The instructions stated, ". . . 1) Position patient's arms on the outside of the harness and have them place their hands on the padded handles. 2) . . . As the patient is being raised, simultaneously tighten the safety strap buckled around their torso. Stop lifting when the patient is in a standing position. . . ." - Review of Resident #5's medical record occurred on all days of survey and diagnoses included muscular weakness and degenerative joint disease. The significant change Minimum Data Set (MDS), dated 06/16/13, identified the resident required extensive assistance of two or more staff members for transfers. The current care plan stated, "Problem: Mobility deficit . . . Plan: . . . Transfer: Assist of (1) - 2 or use stand lift PRN [as needed] . . ." Observation on 07/15/13 at 5:10 p.m. showed two CNAs (certified nursing assistants) (#9 and #17) utilized the sit to stand lift to transfer Resident #5 to the bathroom. As the CNAs lifted the resident to an upright position, he stated, "ouch." The CNAs transferred him onto the toilet. When the resident had finished on the toilet, the CNA (#17) utilized the sit to stand lift and raised him to a squatting position, approximately six inches above the toilet seat, and the CNA (#9) provided	F 323		

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 _____	07/18/2013

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

(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 14	F 323		

perineal cares. The harness slid upward into Resident #5's axilla which caused his shoulders to shrug upward. The resident stated, "uffda." The CNA (#17) failed to lift Resident #5 to a full upright position and failed to tighten the harness around the resident's waist as he stood.

Observation on 07/16/13 at 1:00 p.m. showed the CNA (#7) utilized a sit to stand lift and lifted Resident #5 from his wheelchair. While the resident stood, the CNA (#7) checked his brief for stool and emptied the urine from his Foley catheter bag. The harness around the resident's waist slid upward into Resident #5's axilla and he let go of the right hand grip and stated, "owie, ouch, shit." The CNA (#7) failed to tighten the harness around Resident #5's waist as he stood and failed to encourage the resident to hold onto the hand grip.

Observation on 07/17/13 at 10:45 a.m. showed two CNAs (#6 and #7) utilized the sit to stand lift to transfer Resident #5 from his wheelchair to bed. While in the upright position, the resident let go of the hand grip with left hand, the harness slid upward into his axilla which caused his shoulders to shrug upward. The CNAs failed to tighten the harness around Resident #5's waist as he stood and failed to encourage the resident to hold onto the hand grip.

- Review of Resident #3's medical record occurred on all days of survey and diagnoses included muscular weakness and degenerative joint disease. The quarterly MDS, dated 06/16/13, identified the resident required extensive assistance of one staff member for transfers. The current care plan stated, "Problem: Mobility deficit . . . risk for falls M/B [manifested by] assist with

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 _____	07/18/2013

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

(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 15 transfers . . . Plan: Transfer assist 1 -2 [staff members] . . . stand lift (lge) [large] for toileting & [and] transfer if fatigued as needed . . ." Observation on 07/15/13 at 4:45 p.m. showed a CNA (#23) utilized a sit to stand mechanical lift and transferred Resident #3 from the bed to the bathroom and then to her wheelchair. The CNA lifted the resident to a squatting position. The harness around Resident #5's waist slid upward into her axilla. The hand grips of the lift were above the resident's head which caused her shoulders to shrug upward and her elbows to extend upward as she held onto the grips. The CNA (#23) failed to lift Resident #3 to a full upright position and failed to tighten the harness around the resident's waist as she stood. Observation on 07/16/13 at 5:30 p.m. showed two CNAs (#12 and #24) utilized a sit to stand mechanical lift and transferred Resident #3 from bed to the bathroom. As the CNA (#12) lifted the resident, the harness around her waist slid upward into her axilla and the strap to the harness loosened. Resident #3's shoulders shrugged upward. When the resident finished, the CNA (#12) lifted her up off the toilet to a sitting position just above the toilet and provided perineal cares. The harness around Resident #3's waist remained loose and the resident's elbows extended outward. The CNA (#12) failed to lift Resident #3 to a full upright position and failed to tighten the harness around the resident's waist as she stood. - Review of Resident #1's medical record occurred July 15-18, 2013. Diagnoses included right leg pain, and degenerative joint disease. A quarterly MDS, dated 04/17/13, identified the	F 323		

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 _____	07/18/2013

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

(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 16 resident had severely impaired vision and required extensive assistance of one person for transfers and toileting. Mobility devices included a walker and wheelchair. The care plan, dated 04/23/13, stated "Mobility: W/ FWW [with front wheeled walker] as able with assist or w/c [wheelchair] for distances as needed." Observation on 07/16/13 at 12:45 p.m., showed a CNA (#5) transferred Resident #1 without the use of a gait belt from her wheelchair to the toilet. When the resident had finished in the bathrrom, the CNA (#5) applied a gait belt to the resident's waist and assisted her to her bed without the use of the resident's walker. The CNA failed to use a gait belt when she assisted the resident to the toilet and failed to use the walker when she assisted the resident to the bed. During an interview, on 07/18/13 at 10:40 a.m., an administrative nurse (#1) confirmed staff should follow facility policy and resident care plans for transfers and ambulation. - Review of Resident #8's medical record occurred July 17-18, 2013. Diagnoses included cerebrovascular accident, degenerative central nervous system syndrome, Parkinson's disease, chronic spasticity, and pain. A quarterly MDS, dated 06/06/13, identified the resident required total assistance of two or more persons for bed mobility and transfers. The care plan, dated 06/11/13, stated, "Transfers: Full lift size "M" (signified sling size) assist of 2 to/from bed to w/c." Observation of care for Resident #8, on 07/17/13 at 12:10 p.m., showed two CNAs (#6 and #7) transferred the resident using a mechanical full	F 323		

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 _____	07/18/2013

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

(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 17	F 323		

body lift from her bed to her wheelchair. During the transfer, Resident #8's head lacked support and her neck hyperextended causing her head to fall back. The CNAs (#6 and #7) made no effort to support Resident #8's head during the transfer.

Observation of care for Resident #8, on 07/17/13 at 4:37 p.m., showed two CNAs (#8 and #9) transferred the resident using a mechanical full body lift from her bed to her wheelchair. As the resident raised off the bed her head hyperextended back. One CNA (#8) told the other CNA (#9) to support Resident #8's head. The CNA (#9) attempted to support the resident's head, but could not reach Resident #8's head throughout most of the transfer.

During an interview, on 07/18/13 at 1:55 p.m. an administrative nurse (#3) confirmed Resident #8 was transferred in an unsafe manner.

- Review of Resident #7's medical record occurred on July 15-17, 2013 and diagnoses included history of a traumatic brain injury, left-sided weakness, and osteoarthritis. The annual MDS, dated 05/01/13, identified the resident required extensive assistance of one staff member for transfers. The current care plan stated, "Problem: . . . Mobility deficit R/T [related to] traumantic [sic] brain injury with paralysis M/B [manifested by] assist with transfers, ambulation Hx [history] [and] risk for falls . . . Approaches: Transfer: Stand lift PRN [as needed] . . . or pivot transfer with assist. . . ."

Observation on 07/15/13 at 5:20 p.m. identified a CNA (#13) lifted under Resident #7's left arm to transfer him from his bed to his wheelchair. It took several attempts before the staff member

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 _____	07/18/2013

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

(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 18	F 323		

successfully assisted the resident to pivot to his wheelchair. With each attempt, the staff member lifted up on the resident's left arm and failed to use a gait belt.

- Review of Resident #9's medical record occurred on July 17-18, 2013 and diagnoses included degenerative joint disease (DJD), arthritis, and osteoporosis. The quarterly MDS, dated 06/23/13, identified the resident required extensive assistance of one staff member for transfers. The current care plan stated, "Problem: . . . mobility deficit R/T weakness, DJD, M/B pain to back and knees. Hx of compression fx [fracture], fibular fx, ulnar fx. Hx [and] risk for falls, dx [diagnosis] osteoporosis . . . Approaches . . . pivot transfer assist of (1-2) as needed. . . ."

Observation on 07/17/13 at 4:20 p.m. identified two CNAs (#20 and #22) transferred Resident #9 from her bed to her wheelchair using a gait belt. Both CNAs (#20 and #22) held on to the gait belt with one hand and lifted under her arms with their other hand. The staff members (#20 and #22) failed to correctly use the gait belt.

- Review of Resident #15's medical record occurred on July 18, 2013 and diagnoses included epilepsy, DJD, and muscle weakness. The current care plan stated, "Problem . . . mobility deficit R/T DM [diabetes mellitus], DJD, epilepsy Hx M/B assistance with transfers [and] mobility. Hx [and] risk for falls . . . Approaches . . . transfer with stand lift or pivot transfer of 2. . . ."

During a random observation on 07/18/13 at 10:00 a.m., two CNAs (#18 and #21) transferred Resident #15 from his wheelchair to a recliner in the lounge area. During the transfer, the CNAs

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 _____	07/18/2013

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

(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 19 held onto the loose gait belt around the resident's waist with one hand and lifted up under the resident's arms with their other hand. During an interview on 07/18/13 at 9:45 a.m., an administrative nurse (#1) stated she expected staff to use a gait belt when transferring residents who required staff assistance and to avoid lifting/pulling on residents' arms during transfers.	F 323	F327 1. Immediate verbal staff instruction given, staff to offer fluids during resident contact for residents #1, #2, #6. Resident #5 and #8 discharged July 19, 2013. 2. All residents have the potential to be affected. 3. Immediate staff education provided and reinstruction on procedure of "Hydration of Residents" given on August 20, 2013 at an in-service presented by our consulting dietician. Educational posters on hydration placed throughout building. 4. Audits will be conducted by Dietary, Nursing Staff, QA Coordinator and other designated staff 2 times weekly times two weeks, Then monthly times three months then as deemed necessary by QA committee. 5. Completed August 22, 2013	
F 327 SS=E	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, professional reference review, and staff interview, the facility staff failed to offer fluids to 5 of 6 sampled residents (Resident #1, #2, #5, #6, and #8) dependent on staff for fluid intake. Failure to offer fluids during cares increased the residents' risk of dehydration and may result in Resident #6 experiencing further hospital admissions for dehydration. Findings include: Review of the facility policy titled "Hydration" occurred on 07/18/13. This policy, revised January 2009, stated, ". . . The center will assist each resident in maintaining acceptable parameters of hydration status unless the resident's clinical condition deems this is not possible, such as an end-of-life stage."	F 327		

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 _____	07/18/2013

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

(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 327	Continued From page 20	F 327		

Review of the facility policy titled "Hydration of Residents" occurred on 07/18/13. This policy, revised September 2010, stated, ". . . Purpose: To maintain hydration status of residents . . . 9. Fresh water will be available to the residents at bedside unless contraindicated. 10. Residents needing thickened liquids will have appropriate beverages offered between meals. There will be beverages available on the snack cart that is available to residents between meals. 11. Staff will be trained on the importance of hydration and the signs and symptoms of dehydration. . . ."

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included history of dehydration, dementia, constipation, and current pressure ulcers.

The admission Minimum Data Set (MDS), dated 05/21/13, identified Resident #6 with severely impaired cognition and required extensive assistance for eating. An admission nutrition assessment, dated 05/22/13, identified the resident required 1581 cubic centimeters (cc) of fluids daily.

The current care plan stated, "Problem: . . . H/O [history of] poor food [and] fluid intake (needs much encouragement), H/O dehydration . . . Problem: Alteration in nutrition R/T [related to] ulcer, H/O anorexia, decreased appetite . . . Approaches: . . . Diet: . . . regular, small portions with nutritional supplement 5x [times]/[per] day. . . ."

The interdisciplinary progress notes identified Resident #6 was hospitalized from May 10-14, 2013 for dehydration, admitted to the nursing

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 _____	07/18/2013

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

(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 327	Continued From page 21 home on May 21, 2013, and hospitalized again from July 12-15, 2013 for dehydration and cellulitis. Observations of Resident #6's cares identified the following: *07/15/13 at 4:45 p.m. - Two certified nursing assistants (CNAs) (#13 and #17) assisted the resident out of bed, toileted her, and transported her to the lounge area. The staff members (#13 and #17) failed to offer Resident #6 fluids during their interaction with the resident. *07/16/13 at 1:50 p.m. - A CNA (#18) attempted to transfer the resident into the bathroom and the resident declined. The CNA (#18) failed to offer fluids to Resident #6 at this time. *07/16/13 at 2:25 p.m. - Two licensed nurses (#1 and #14) assessed the resident's skin and changed her dressings while she sat in her wheelchair. The staff members (#1 and #14) failed to offer fluids prior to leaving the resident's room after completing the treatments. *07/16/13 at 2:40 p.m. - A CNA (#19) transferred the resident from the wheelchair to her bed and failed to offer the resident fluids at anytime during the observation. *07/16/13 at 3:00 p.m. - Two CNAs (#19 and #20) changed the resident's brief and repositioned her in bed. The staff members failed to offer fluids during this care observation. *07/17/13 at 9:05 a.m. - Two CNAs (#18 and #19) toileted the resident and assisted her to lay down. The staff members failed to offer fluids during cares. During an interview on 07/18/13 at 9:45 a.m., an administrative nurse (#1) stated she expected staff to offer residents fluids with cares.	F 327		

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 _____	07/18/2013

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

(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 327	Continued From page 22 - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included constipation and a history of dehydration. The signification change MDS, dated 06/16/13, identified Resident #5 as having both long and short term memory problems and required extensive assistance for eating. An annual nutrition assessment, dated 09/25/12, identified the resident required 1,977 cc of fluids daily. The current care plan stated, "Problem: . . . Alteration in nutrition . . . Hx [history] of dehydration, weight loss, constipation . . . Approaches: . . . Encourage fluids, snacks throughout the day; high calorie/high protein foods/fluids daily PRN . . ." Review of Resident #5's progress notes identified the following: * 06/12/13 (nursing note) - "[nurse's name] RN notified GSS [Good Samaritan Society] & [and] stated that [doctor's name] said that [Resident #5] was severely dehydrated & push fluids . . . Fluids encourage frequently throughout the day & resident will only drink what he wants to drink." * 06/13/13 (nursing note) - ". . . Wife [name] stated '[Resident #5] hates that thick fluids, please do not give it to him.'" Dietary - dc'd [discontinued] nectar thickened liquids trial per family." * 06/17/13 (dietary note) - ". . . needing limited to extensive assistance @ [at] meal times. Rarely eats per self anymore. Needing encouragement et [and] cueing as well . . . Intakes average . . . 901 cc of fluids daily . . . On 6-12-13, a UA [urinalysis] was sent to clinic et orders were to push fluids as resident was severely dehydrated .	F 327		

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 _____	07/18/2013

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

(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 327	Continued From page 23 . ." * 07/15/13 (dietary note written the week of survey) - "[Resident #5] is on hospice; assessed for [significant change] R/T declining health status . . . Intakes average . . . 869 cc of fluids daily . . . Dehydration probable as unable to communicate if thirsty . . ." Review of the "Dining Report" identified the fluid, nourishments, and supplements consumed by a resident for the day. Resident #5's report identified an intake of 420 cc on 07/15/13, 360 cc on 07/16/13, and 360 cc on 07/17/13. Observations showed the following: * 07/15/13 at 4:15 p.m. - Resident #5 seated in a recliner in the commons area and no fluids available. At 5:10 p.m., two CNAs (#9 and #17) assisted Resident #5 out of the recliner, transported him to the bathroom via wheelchair, and then to the dining room. Observation showed a large covered mug of water on a table in the resident's room but the CNAs failed to offer him water. * 07/16/13 at 1:00 p.m. - A CNA (#7) transported Resident #5 from the commons area to his bathroom and then transferred him onto his bed. The CNA failed to offer the resident fluids from the mug on his table. Observation showed the table and the mug of water not within the resident's reach while in bed. At 3:55 p.m., a CNA (#8) repositioned Resident #5 from his left side to his right side. The CNA failed to offer fluids. At 5:45 p.m., Resident #5 remained positioned on his right side. * 07/17/13 at 12:45 p.m. - Two CNAs (#7 and #13) assisted Resident #5 from his wheelchair to bed. The CNAs failed to offer him fluids.	F 327		

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 _____	07/18/2013

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

(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 327	Continued From page 24 During an interview on the morning of 07/18/13, an administrative nurse (#2) stated she expected staff to offer Resident #5 fluids during cares. - Review of Resident #1's medical record occurred July 15-18, 2013. Diagnoses included constipation and a history of swallowing problems. A quarterly MDS, dated 04/17/13, identified the resident required extensive assistance of one person for eating. The care plan, dated 04/23/13, stated, " . . . Assisted table & [and] assist with eating . . ." Observation of care on 07/16/13 at 8:55 a.m., showed a CNA (#11) assisted Resident #1 with personal cares in her room. After cares, the CNA (#11) took Resident #1 to the lounge and transferred the resident into a recliner. The CNA (#11) failed to offer fluids during cares and Resident #1 was not observed to receive fluids until the noon meal three hours later. - Review of Resident #2's medical record occurred July 15-18, 2013. Diagnoses included severe dehydration and constipation. A quarterly MDS, dated 06/23/13, identified the resident required limited assistance of one person for eating, and had a mechanically altered diet. The care plan, dated 06/26/13, stated, " . . . assisted table-assist as needed . . ." Observation of cares for Resident #2 showed the following: * On 07/16/13 at 9:10 a.m., a CNA (#5) removed Resident #2 from the exercise group and took her to her room for toileting. During these cares, the CNA (#5) failed to offer Resident #2 fluids. * On 07/16/13 at 5:01 p.m., a CNA (#12) woke Resident #2 and assisted her with cares. During	F 327		

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 _____	07/18/2013

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

(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 327	Continued From page 25 these cares, the CNA (#12) failed to offer Resident #2 fluids. Resident #2 had been assisted to bed at 1:40 p.m., approximately three hours earlier. * On 07/17/13 at 11:40 a.m., a CNA (#13) woke Resident #2 and assisted her with cares. During these cares the CNA (#13) failed to offer Resident #2 fluids. - Review of Resident #8's medical record occurred July 17-18, 2013. Diagnoses included dysphagia, and slow transit constipation. A quarterly MDS, dated 06/06/13, identified the resident required total assistance of one person for eating. The care plan, dated 06/11/13, stated, "Problem: Potential for fluid volume deficit r/t [related to] daily use of diuretic medication and need for thickened liquid . . . Approaches s/s [signs/symptoms] poor fluid intake: monitor for dry mucous membranes or skin, decreased urinary output, change in vital signs, encourage increased fluid intake." Observations of Resident #8 showed the following: * On 07/17/13 at 11:42 a.m., a glass of thickened water on the bedside stand dated 07/16/13, with an intact aluminum foil covering. * On 07/17/13 at 12:10 a.m., two CNAs (#6 and #7) woke Resident #8 and assisted with cares. During these cares, the CNAs (#6 and #7) disposed of the thickened water from the day before and failed to offer Resident #8 fluids. - During the dietary tour, on 07/17/13 at 3:03 p.m., an administrative dietary staff member (#4) identified the kitchen staff thickened water for Resident #8 daily. This staff member (#4) stated staff pass fresh water to the residents' room	F 327		

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 _____	07/18/2013

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

(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 327	Continued From page 26 between 10 a.m. and 11 a.m.	F 327		
F 371 SS=C	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of manufacturer's instructions, and staff interview, the facility failed to clean and sanitize 1 of 1 ice machine located in the dining room, per manufacturer's instructions. Failure to clean and sanitize the ice machine may result in residents ingesting contaminated water. Findings include: Review of the facility policy titled "Sanitation - ICE/ICE SCOOP/ICE MACHINE" occurred on 07/18/13. This policy, revised May 2004, stated, ". . . 5. Clean/sanitize the ice scoop twice a day or 'as needed' . . ." Review of the instruction manual for the "Scotsman Ice System" occurred on 07/18/13. This manual, dated May 2001, stated, ". . . Maintenance and Cleaning should be scheduled at a minimum of twice per year. Sanitizing of the	F 371	F371 1. Ice Machine has been sanitized per manufactures recommendations on 7-19-13 using 1 ounce of household bleach mixed with 2 gallons of warm ….water... 2. All residents have the potential to be affected. 3. Environmental Services educated on procedure to clean the ice machine. Sanitizing of ice machine was added to the TELS program (preventive maintenance program) for quarterly sanitizing. 4. Environmental Services or others as assigned will complete audits 1 time quarterly times 2 quarters, then as deemed necessary by QA Committee. 5. Completed 8-22-2013. Training occurred on 7/19/2013 Per Julie Skorheim, DON 8/29/13 at 1140 QA expires RN	

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 _____	07/18/2013

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

(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 371	Continued From page 27 ice storage bin should be scheduled for a minimum of 4 times a year . . . ICEMAKING SYSTEM: In place cleaning . . . 7. Prepare the cleaning solution: Mix eight ounces of Scotsman Ice Machine Cleaner with three quarts of hot water. The water should be between 90-115 degrees F (Fahrenheit) . . . To Sanitize: . . . only use an approved sanitizing solution in place of the cleaning solution. A possible sanitizing solution to use could be 1 ounce of household bleach mixed with 2 gallons of warm . . . water . . . ." Observation with an environmental service staff member (#10) on the morning of 07/18/13 showed an ice machine located in the dining room (available to residents, visitors, and staff). The staff member (#10) stated an employee cleaned the cooling coils in the ice machine on a monthly basis and confirmed the facility failed to clean and sanitize the inside of the machine. During an interview on 07/18/13 at 8:50 a.m., a dietary staff member (#4) confirmed their department only wiped down the outside of the ice machine and did not clean or sanitize internal components.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		

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 _____	07/18/2013

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

(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 441	Continued From page 28 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of facility policy, review of professional reference, and staff interview, the facility failed to follow standard infection control practices for 1 of 1 sampled resident (Resident #2) observed receiving dressing changes and 5 of 9 sampled residents (Resident #1, #2, #3, #6, and #9) observed during personal cares with regard to hand hygiene. Failure to follow infection	F 441		

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 _____	07/18/2013

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

(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 441	Continued From page 29 control practices related to handling of medical equipment (scissors), glove usage and hand hygiene has the potential to cause spread of infection within the facility. Findings include: Review of the facility policy titled "Resident Health Multidrug-Resistant Organisms (MRSA . . .)" occurred on 07/18/13. This policy, dated April 2013, stated, "Purpose * To provide guidance in managing care for residents with multidrug-resistant organisms. . . Contact Precautions . . . 3. Equipment * Dedicate resident care equipment when needed (e.g., commodes, blood pressure cuffs). If equipment is to be shared, it must be cleaned and disinfected before use by another resident. . . ." Review of the facility policy titled "Perineal Care" occurred on 07/18/13. This policy, dated November 2009, stated, ". . . 2. Wash hands and put on gloves. (If additional supplies are needed during perineal care, remember to remove soiled gloves, wash hands or use hand sanitizer before touching objects in environment. Re-glove to resume perineal care.) . . . 7. Turn resident on side to wash, rinse and dry anal area. After removing soiled gloves, use hand sanitizer or wash with soap and water to cleanse hands. Put on clean gloves to put on clean pad and/or clothing. 8. Remove and discard gloves and wash hands. . . ." Kozier and Erb's "Fundamentals of Nursing," 9th edition, Pearson Education, Inc., New Jersey, pages 689-690, stated, Hand Hygiene . . . 5. Dry hands ... thoroughly with a paper towel . . .6. Turn off the water. Use a new paper towel to grasp a	F 441	F 441 1. Immediate verbal instructions were given to nurses on proper handling of medical equipment for resident #2. Immediate verbal instruction given by nurse manager to C.N.A.s on proper hand hygiene and glove use during cares for residents #1, #2, #6, & #9. Resident #3 discharged on July 22, 2013. 2. All residents receiving wound and personal care have the potential to be affected. 3. An in-service on proper practices and expectations related to handling of medical equipment, glove usage and hand hygiene was conducted on August 20, 2013 by the Infection Preventist and DNS. 4. DNS or designee will audit twice weekly times two weeks then weekly times four weeks on the proper use of medical equipment. Audits on glove usage and hand hygiene will be conducted on all shifts weekly times two weeks then random weekly times four weeks. Audit finding will be report to Quality Assurance committee for further recommendations. 5. Completed August 22, 2013	

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 _____	07/18/2013

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

(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 441	Continued From page 30	F 441		

hand-operated control. Rationale: This prevents the nurse from picking up microorganisms from the faucet handles. . ."

- Review of Resident #2's medical record occurred July 15-18, 2013. A physician order, dated 07/12/13, identified Resident #2 had a MRSA (Methicillin Resistant Staphylococcus Aureus) infection and staff were to administer Cipro (an antibiotic) for seven days. Nursing documentation identified the location of the MRSA infection as a pressure ulcer on Resident #2's right heel, and nursing staff changed the dressing daily.

During an observation, on 07/16/13 at 9:50 a.m., two nurses (#1 and #14) removed the dressing on Resident #2's right heel pressure ulcer. The nurse (#14) cut off the dressing using a scissor and observation showed yellow drainage on the dressing. The nurse (#14) cut a clean dressing with the same scissor and applied the telfa dressing covered with gauze to the pressure ulcer. The nurse (#14) failed to clean and disinfect the scissor before she cut the clean dressing and before she exited Resident #2's room.

During an observation on 07/17/13 at 2:37 p.m., two nurses (#1 and #14) removed the dressing from Resident #2's right heel pressure ulcer. The nurse (#14) removed a scissor from her pocket and cut off the dressing. Observation showed yellow/orange drainage on the dressing. The nurse placed the contaminated scissor on a calendar on Resident #2's overbed table. The nurse (#14) cut a clean dressing with a second scissor which she obtained from her pocket, redressed the pressure ulcer with telfa and

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 _____	07/18/2013

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

(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 441	Continued From page 31	F 441		

gauze, and placed the scissor on the table next to the first scissor. The nurse (#14) picked up both scissors, placed them in her pocket, and exited the room. The nurse #14 failed to clean and disinfect the scissors.

Failure to clean and disinfect the scissor between the soiled and clean dressing, to clean and disinfect the scissors before putting them in her pocket, and failure to clean and disinfect the scissors prior to leaving the resident's room may result in the spread of MRSA to other residents, staff, and visitors.

- Observation on 07/16/13 at 12:27 p.m. showed a certified nursing assistant (CNA) (#5) donned gloves, placed a gait belt on Resident #1, assisted her to stand, and provided perineal cares. Without removing her gloves, the CNA assisted the resident to her bed by holding her hand and the gait belt, arranged her pillow, applied a clip alarm tab to the resident's shirt, and gave her the call light. The CNA (#5) then removed her gloves, washed her hands, and turned off the water faucet with her bare, wet hand, and dried her hands with a paper towel. The CNA (#5) failed to remove her gloves after providing perineal cares and perform hand hygiene and failed to use a paper towel to turn the faucet off.

- Observation on 07/16/13 at 1:40 p.m. showed a CNA (#5) utilized a mechanical sit to stand lift, transferred Resident #2 to the bathroom, removed the resident's soiled brief and assisted the resident onto the toilet. The CNA (#5) washed her hands, turned off the water with her bare clean hand, and dried her hands with a paper towel. When Resident #2 finished on the toilet,

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 _____	07/18/2013

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

(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 441	Continued From page 32	F 441		

the CNA (#5) donned gloves, performed perineal care, and dressed the resident. The CNA (#5) removed the gloves, washed her hands, turned off the water with her bare, wet hand, and dried her hands with a paper towel. The CNA (#5) transferred Resident #2 to her bed with the sit to stand lift, offered water, and gave the resident her call light, bed controls, and secured the personal alarm. The CNA (#5) washed her hands again, turned off the water with her bare, wet hand, and dried her hands with a paper towel. The CNA (#5) failed to use a paper towel to turn the faucet off.

- Observation on 07/17/13 at 11:40 a.m. showed a CNA (#13) donned gloves and provided perineal cares to Resident #2. The CNA (#12) removed her gloves, positioned Resident #2 in her wheelchair, and placed a nasal cannula to the resident's nose for oxygen administration. The CNA (#12) failed to preform hand hygiene after providing perineal cares and before assisting Resident #2 with other cares.

- Observation on 07/17/13 at 12:40 p.m. showed Resident #2 seated on the toilet. Two CNAs (#15 and #16) utilized a mechanical lift and stood Resident #2 upright, provided perineal cares, transferred her to a wheelchair, and exited the room. The CNAs (#15 and #16) failed to perform hand hygiene following perineal care and/or prior to leaving the room.

- Observation on 07/15/13 at 4:45 p.m. showed a CNA (#23) utilized a sit to stand lift and transferred Resident #3 from her bed to the bathroom. The CNA donned gloves, removed the resident's saturated brief, lowered her to the toilet, and removed her gloves. The CNA washed her hands, donned clean gloves, and provided

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 _____	07/18/2013

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

(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 441	Continued From page 33	F 441		

perineal cares. The CNA (#23) removed her gloves, transferred Resident #3 to her wheelchair and transported her out to the commons area. The CNA then returned to the resident's room and washed her hands. The CNA (#23) failed to perform hand hygiene before transporting Resident #3 out of the room.

During an interview on the morning of 07/18/13, an administrative nurse (#3) stated she expected staff to perform hand hygiene after completing personal cares and before exiting the resident's room.

- Observation on 07/17/13 at 9:05 a.m. showed two CNAs (#18 and #19) assisted Resident #6 to the bathroom and removed her wet brief. The CNA (#18) completed perineal cares, removed her gloves and applied a clean brief. The two CNAs utilized a mechanical lift and transferred Resident #6 to bed. The CNA (#18) placed heel boots on the resident's feet, put a pillow under her legs, covered the resident with a blanket, bagged the garbage, and exited the resident's room with the garbage. The CNA (#18) re-entered Resident #6's room to assist the resident's roommate to the toilet. The CNA (#18) failed to perform hand hygiene after completing perineal cares on Resident #6 and before helping her roommate to the bathroom.

- Observation on 07/17/13 at 11:55 a.m. showed a CNA (#7) changed Resident #9's brief, incontinent with a large amount of loose stool, as the resident lay in bed. After completing perineal cares, the CNA (#7) removed her gloves, changed the resident's pants and socks, put on her shoes, transferred her from her bed to her wheelchair using a gait belt, placed footpedals on

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 _____	07/18/2013

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

(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 441	Continued From page 34 the wheelchair, combed the resident's hair, and then washed her hands. The CNA (#7) failed to wash her hands immediately after completing perineal cares. During an interview on 07/18/13 at 9:45 a.m., an administrative nurse (#1) stated she expected staff to perform hand hygiene immediately after completing perineal care and removing their gloves.	F 441		