DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2010
FORM APPROVED
OMB NO. 0938-0391

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 _____	05/06/2010

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

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid survey started on 05/03/10 and completed on 05/06/10, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review.	F 000	"Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or 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 ~~ND requirements for Food and Beverage Establishments.~~ Center for Medicare + Medicaid Services – per telephone call & QA Coordinator. 05/25/2010 KH	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure residents received the assistive devices necessary to prevent accidents for 1 of 1 sampled resident (Resident #10) who required a walker for in-room ambulation, and for 1 of 3 sampled residents (Resident #5) whose care plan indicated a need for a wheelchair alarm. Failure to provide these assistive devices poses a risk to resident safety and has the potential to result in avoidable accidents. Findings include: - Review of Resident #10's medical record occurred on 05/05/10. Diagnoses included hypertension, anemia, congestive heart failure, atrial fibrillation, and generalized pain. The resident's most recent Minimum Data Set (MDS),	F 323	1. Wheelchair alarm applied to wheelchair of resident #5 on 5-4-10. Physical therapist reviewed resident #10 for use of walker in-room ambulation with no changes made. Consulting Pharmacist did a medication review on resident #10 with no changes. (per 9.e) 2. All residents whose care plan indicates a need for an alarm and who require a walker for in-room ambulation have the potential to be affected in this area. A list of all residents with	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joan Olson — TITLE: Administrator — (X6) DATE: 5-19-10

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 323	Continued From page 1 dated 3/16/10, indicated the resident experienced dizziness, an unsteady gait, a fall in the past 30 days, a fall in the past 31-180 days, and required limited assistance from one person with in-room ambulation. Resident #10's medications included Metoprolol (an antihypertensive which may cause dizziness and fatigue) and Lasix (a diuretic which may cause dizziness, vertigo, and weakness). The most recent care plan for Resident #10, dated 03/17/10, stated, ". . . Problems/Needs/Concerns . . . Mobility Deficit r/t [related to] [left] foot fx [fracture] of toes, weakness m/b [manifested by] weight bearing as tolerated, unsteady gait, hx [history] & at risk for falls . . . Plans and Approaches . . . Mobility: W/C [wheelchair] for distances, propelled by staff, unable to ambulate independently, FWW [front-wheeled walker] . . . Ambulate- FWW with assist 1 . . ." A form in the resident's chart entitled "Nursing Documentation" and dated 04/07/10 stated, ". . . FWW for short distances in rm [room]. . . ." Observation on 05/05/10 at 11:45 a.m. showed a certified nursing assistant (CNA) (#7) assisted Resident #10 from the toilet to the sink (located approximately 10 feet from the toilet). The CNA used a gait belt around the resident's waist and walked beside her, holding the gait belt with one hand. During this observation, the resident was unsteady on her feet and held onto the wall with one hand for support. While the resident washed her hands, the CNA held onto the gait belt with one hand and used the other hand to pull the resident's wheelchair behind the resident. The resident then sat in the wheelchair. Observation showed the resident's walker located in the room, but the CNA failed to use it to assist with	F 323	personal alarms was reviewed to ensure residents safety. A query was run to identify residents who require assistance to ensure residents safety. Care plans will be reviewed and revised as needed. 3. Education of nursing staff on 5-18-10 to educate the use and checking of alarms and the use of walkers for in-room ambulation. A check list will be initiated when a personal alarm is implemented to ensure care plan accuracy. Daily check list form for personal alarms was revised. 4. Rehab Coordinator or designee will audit alarm placement daily times five days, weekly times two weeks monthly times 2 months with results of audits reported to QA committee for further recommendations. Rehab Coordinator or designee will audit use of walkers for in-room ambulation 2 times weekly times 2 weeks, 1 time monthly times 1 month with results of audits reported to QA committee for further recommendations. QA will begin on 05/14/2010 - per telephone call with QA Coordinator. 05/25/2010 KH (per q.c.)	6-10-10

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F 323	Continued From page 2 ambulation. In an interview on 05/05/10 at 1:15 p.m., a CNA (#7) stated she just finished assisting Resident #10 to the bathroom and to bed. The CNA stated she used a gait belt and walked alongside the resident. Observation on 05/05/10 at 4:50 p.m. showed two CNAs (#2 and #8) assisted Resident #10 out of bed. A CNA (#2) walked with the resident to the bathroom, holding on to a gait belt around the resident's waist. The resident was unsteady on her feet and used the sink to balance herself. The CNA (#2) stated, "She's a little wobbly at first. Unsteady." After the resident used the toilet, the CNA (#2) assisted her to the sink, another CNA (#8) moved the wheelchair behind the resident, and the resident sat down. Observation showed the resident's walker located in the room, but the CNAs failed to use it to assist with ambulation. - Review of Resident #5's medical record occurred on 05/04/10. Diagnoses included Dementia with depressed mood, osteoporosis, and anxiety. The most recent MDS, dated 03/04/10, indicated severely impaired daily decision making skills and fall in the past 31-180 days. A form in the resident's chart entitled "Nursing Documentation" and dated 03/05/10 stated, ". . . Bed sensor on bed, tab alarm W/C [wheelchair]. . . ." Resident #5's current care plan, last updated 03/18/10, stated, ". . . Problems/Needs/Concerns . . . Mobility deficit r/t dementia m/b hx & risk for falls, use of walker with ambulation- SBA [stand by assist] x1, forgets walker at times . . . Plans and Approaches . . . SBA [with] FWW may need	F 323		

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F 323	Continued From page 3 redirection or reminders at times or W/C [with] cushion [and] tab alarm . . ." Observation on 05/03/10 at 3:50 p.m. showed a CNA (#9) assisted Resident #5 to the bathroom using a walker and gait belt. After the resident used the toilet and washed her hands, the CNA helped the resident sit in the wheelchair and transferred her to the lounge area. The resident's wheelchair lacked an alarm, and the CNA failed to obtain one. Observation on 05/04/10 at 7:38 a.m. showed Resident #5 dressed and seated in her wheelchair in the lounge area. The resident's wheelchair lacked an alarm. Observation on 05/04/10 at 9:23 a.m. showed two CNAs (#2 and #10) assisted Resident #5 to the bathroom. After the resident used the toilet, the CNAs wheeled the resident to the activities area for exercises. The resident's wheelchair lacked an alarm, and the CNAs failed to obtain one. Observation on 05/04/10 at 12:10 p.m. showed Resident #5 seated in her wheelchair in the dining room. The resident's wheelchair included an alarm. Review of the Resident #5's "Daily Checklist for TABS Pressure Pads" indicated a daily check for the wheelchair "tab" alarm. On 05/03/10 and 05/04/10, record review showed the checklist initialed and marked "a.m." (referring to morning) and "ok." This indicated the tab alarm was in place, although observation showed the tab alarm missing from the resident's wheelchair. In an interview on 05/05/10 at 5:20 p.m., a	F 323		

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F 323	Continued From page 4 nursing staff member (#11) stated a nurse noticed Resident #5 did not have a wheelchair alarm so she put one on Resident #5's wheelchair before lunch on 05/04/10.	F 323		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, scoop sizes guidance review, and staff interview, the facility failed to serve food in the correct portions for each diet identified in the prepared menus during 2 of 3 meal observations (05/04/10 noon and evening meals). When a resident is served menu items with an incorrect serving utensil, there is potential the nutritional needs (calories and protein) of the resident will not be met and may result in resident(s) experiencing weight loss. Findings include: Review of the facility's policy "Portion Control," revised March 2009, occurred on the afternoon of 05/05/10. The policy stated, "Policy: Standard portions will be served for all food items to ensure nutritional adequacy and to avoid food waste. Procedure: 1. The portion sizes listed on the menu extensions will be followed. Portion sizes for menu extensions must be referred to during	F 363	1. Additional scoops have been ordered. 2. All residents have the potential to be affected in this area; staff will use correct scoops when serving each diet. 3. Mandatory dietary staff meeting held 5-19-10 to educate staff on the facilities policies for portion control and the correct scoops for proper portion sizes. The policy on textured altered diets was reviewed including the need to follow standardized recipes for pureed and ground diets. 4. Dietary Manager or designee will audit for proper scoop size and proper portions served 3 times weekly times 2 weeks, 2 times monthly for 1 month and 1 times quarterly for 2 quarters with results of audit reported to QA committee for further recommendations. QA will begin on 05/20/2010 per telephone call c QA Coordinator on 05/25/2010 K.H. (per J.C.)	6-10-10

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F 363	Continued From page 5 meal service. . . . 2. Standard portion control scoops and ladles will be used. . . . 4. The Portion Control Guidelines may be posted in the kitchen for reference by staff. . . . " - Observation of tray line at the noon meal on 05/04/10 at 12:10 p.m., showed a dietary staff member (#3) served the meal and used the following serving utensils: *Pureed meat balls - one #16 (2 ounces) scoop *Ground meat balls - one #16 (2 ounces) scoop During an interview on 05/04/10 at 12:15 p.m., a dietary staff member (#3) identified dietary staff look at the menu posted above the steam table to determine scoop sizes. Review of the menu on the afternoon of 05/04/10 revealed the portions served at the noon meal to be less than the following planned serving sizes: *Dysphagia (Pureed) - one #8 (4 ounces) scoop *Dysphagia (Mechanical Soft) (ground) - one #12 (2.6 ounces) scoop - Observation of tray line at the evening meal on 05/04/10 at 5:50 p.m., showed a dietary staff member (#4) served the meal and used the following serving utensils: *Pureed turkey - one #16 (2 ounces) scoop During an interview on the afternoon of 05/05/10 at 12:15 p.m., an administrative dietary staff member (#5) identified eight residents received regular portion pureed diets and three residents received regular portion mechanical soft diets. This staff member confirmed when serving pureed meat to residents dietary staff should use a #8 (4 ounces) scoop and agreed the menu items should be served in the amounts identified on the menu.	F 363		

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F 441 SS=D	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 - (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.	F 441	1. For Residents #6 and #3 education of proper catheter drainage bag emptying was given to C.N.A.'s via standup meetings on 5-7-10 and 5-8-10. 2. All residents with catheters have the potential to be affected in this area. 3. Education of nursing staff on 5-18-10 to educate on catheter drainage bag emptying procedures. Nursing staff will also complete Computerized Learning Center education entitled "Catheter Care". 4. QA Coordinator or designee will audit catheter drainage bag emptying weekly times two weeks, monthly times three months with results reported to QA Committee for further recommendations QA will be begin on 05/19/2010 - per telephone call & QA Coordinator on 5/25/2010. K.H. (per J.C.)	6-10-10

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F 441	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, facility procedure review, and staff interview, the facility failed to follow infection control practices during 2 of 5 observations of catheter drainage bag emptying. Failure to follow infection control practices places residents at risk of developing infections. Findings include: Review of the facility's procedure entitled, "CATHETER DRAINAGE BAG EMPTYING," occurred on 05/05/10. This procedure, revised November 2009, stated, ". . . PROCEDURE . . . 2. Open drainage port and allow urine to drain into measuring container placed underneath. . . . 3. When done, clean drainage port tip with alcohol wipe and replace in the holder. . . ." - Review of Resident #6's medical record occurred on 05/04/10. Medical diagnoses included urinary retention with a Foley catheter placed and a history of urinary tract infections. Observation on 05/04/10 at 1:30 p.m. showed a certified nursing assistant (CNA) (#2) entered Resident #6's room to empty her catheter bag. The CNA drained the urine into a plastic graduate, clamped the drainage tubing, and placed the tubing back into the holder. The CNA failed to clean the drainage port with an alcohol wipe. - Review of Resident #3's medical record occurred May 05-06, 2010. Medical diagnoses included dementia and hip fracture. Following hospitalization, Resident #3 returned to the facility on 05/03/10 with physician orders for a Foley	F 441		

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F 441	Continued From page 8 catheter. Review of a quarterly Minimum Data Set (MDS), dated 04/22/10, identified Resident #3 required total assistance of two staff for personal hygiene and toileting. Observation of personal cares for Resident #3 occurred on 05/04/10 at 1:00 p.m. A CNA (#1) drained the urine into a plastic graduate, clamped the drainage tubing, and placed the tubing back into the holder. The CNA (#1) failed to cleanse the tip of the drainage tubing with alcohol as per facility policy. During an interview on 05/05/10 at 3:50 p.m., a nursing staff member (#6) stated the use of an alcohol wipe with catheter cares is expected as per facility policy.	F 441		