STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____ MAR 29 2010	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 and complaint surveys started on 02/22/10 and completed on 02/25/10, the sample included 3 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 3 additional residents to verify specific concerns during the survey.	F 000	**General Disclaimer** 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 it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 203 SS=C	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.	F 203		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ronald D Hodges	Administrator	03/26/10

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 203	Continued From page 1 The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of facility policy and procedure, the facility failed to notify the resident and/or the resident's family/legal representative, in writing, of a transfer, including the destination and the reason for the transfer, and the resident's right to appeal the action, for 3 of 4 sampled residents (Residents #1, #3, #8) and 1 closed record (Residents #13) transferred to the hospital. Findings include: Review of the facility policy titled "Discharge/Transfer" occurred on 02/25/10. This	F 203	F203 Transfer/Discharge Notice **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Residents #1, #3 and #8 individual needs have been met as they have returned to the facility. Resident #13 expired during her hospital stay. **2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All resident that live in the GSS Devil's Lake have the potential to be effected in this area. Currently, no other residents have been transferred out of the facility and not returned. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** Licensed Nursing Staff have been educated on March 30, 2010 on the Transfer/Discharge policy. Social Service has been educated on the Transfer/Discharge policy on 3/30/10.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 203	Continued From page 2 policy, dated October 2009, stated, ". . . Notice Before Transfer . . . The center will . . . prior to . . . transfer, notify the resident and, if known, a family member or legal representative of the . . . discharge and the reasons, record the reasons in the medical record, and include appropriate information in the written notice . . . In cases of . . . improvement of resident's health that allows immediate action . . . notice may be made as soon as practicable. The written notice will be in a language and manner that residents and family can understand and will include the following: 1. Reason for . . . transfer, 2. Effective date of . . . transfer, 3. Location to which resident is transferred . . . 4. A statement that the resident has the right to appeal the action . . . 5. Name, address and telephone number of the state's long-term care ombudsman . . ." The medical records for Resident #1, #3, #8 and #13, reviewed on all days of survey, identified the following: * The facility transferred Resident #1 to the hospital on 12/06/09. Resident #1 returned to the facility on 12/15/09. * The facility transferred Resident #3 to the hospital on 11/17/09. Resident #3 returned to the facility on 11/19/09. * The facility transferred Resident #8 to the hospital on 07/03/09. Resident #8 returned to the facility on 07/13/09. * The facility transferred Resident #13 to the hospital on 07/20/09. Resident #13 expired during her hospital stay. The records for all four residents lacked evidence the facility provided the residents and their family/legal representative written notice of the transfers, including the reason for the transfers,	F 203	**System Change:** Social Service will be responsible to check the next working day after a resident has been transferred or discharged to make sure the policy was properly followed. Social Service will immediately correct any problem. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** Health Information Management (HIM) will audit 100% of all transfer/discharges to make sure transfer/discharge policy was followed. Audit results will be submitted to the QA/CQI on a monthly basis for 3 months for further recommendations. 5. April 5, 2010	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 203	Continued From page 3 the effective date of the transfers, the location to which they transferred the residents, and the right to appeal the actions. During an interview on 02/25/10 at 11:45 a.m., the administrator (#1), the director of nursing (#2), and an administrative nursing staff member (#3) confirmed all four residents' records lacked evidence the facility provided notice of transfers for the above hospitalizations.	F 203	F205 Bed Hold Policy Notice **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Residents #1, #3 and #8 individual needs have been met as they have returned to the facility. Resident #13 expired during her hospital stay.	
F 205 SS=C	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of facility policy and procedure, the facility failed to provide the resident and/or their	F 205	**2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All residents that transfer out of the center over night have the potential to be effected by the bed hold notice. No other residents have been transferred out of the facility and not returned. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** Licensed Nursing Staff have been educated on the Bed Hold Notice policy on March 30, 2010. Social Service has been educated on the Bed Hold Notice policy on 3/30/10. **System Change:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 205	Continued From page 4 family/legal representative written information regarding the facility's bed hold policy for 3 of 4 sampled residents (Residents #1, #3, #8) and 1 closed record (Residents #13) transferred to the hospital. Findings include: Review of the facility policy titled "Bed-Hold" occurred on 02/25/10. This policy, dated October 2009, stated, ". . . Upon Transfer: 1. The social worker or designated individual will provide the Notice of Bed-Hold Policy . . . to resident and/or responsible party which specifies the duration of the bed-hold policy under the state plan and the center policy regarding bed-holds. 2. The social worker or designated individual will explain the Notice of Bed-Hold Policy and answer questions. Be certain it is understood that future admission is based on bed availability and the criteria listed . . . 3. In case of emergency transfer the resident's copy of the Notice of Bed-Hold Policy is sent with the other papers accompanying the resident to the hospital. The family member or legal representative, if any, is provided the Notice of Bed-Hold Policy within 24 hours of the transfer. . . . b. The charge nurse is responsible for completion of notification procedures if the transfer occurs at a time the social worker is not at the center. . . . 4. The social worker or designated individual will contact resident/responsible party to inquire of their decision for holding a bed. . . ." The medical records for Residents #1, #3, #8 and #13 reviewed on all days of survey, identified the following: * The facility transferred Resident #1 to the hospital on 12/06/09. Resident #1 returned to the	F 205	Social Service will be responsible to check the next working day after a resident has been transferred or discharged to make sure the bed hold notice policy was properly followed. Social Service will immediately correct any problem. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** Health Information Management (HIM) will audit 100% of all transfer/discharges to make sure the bed hold policy was followed. Audit results will be submitted to the QA/CQI on a monthly basis for 3 months for further recommendations or action needed to ensure compliance in this area. 5. April 5, 2010	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 205	Continued From page 5 facility on 12/15/09. * The facility transferred Resident #3 to the hospital on 11/17/09. Resident #3 returned to the facility on 11/19/09. * The facility transferred Resident #8 to the hospital on 07/03/09. Resident #8 returned to the facility on 07/13/09. * The facility transferred Resident #13 to the hospital on 07/20/09. Resident #13 expired during her hospital stay. The records for all four residents lacked evidence the facility provided the residents and the their family/legal representative written information regarding the facility's bed-hold policy. During an interview on 02/25/10 at 11:45 a.m., the administrator (#1), the director of nursing (#2), and an administrative nursing staff member (#3) confirmed all four residents' records lacked evidence the facility provided bed-hold policies for the above hospitalizations.	F 205		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy and procedure, the facility failed to provide assistance with toileting and meals in a manner that maintains resident's dignity for 3 of 12 sampled residents (Resident #2, #4, and #5).	F 241	F241 Dignity **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #2, #4 and # 5 have been assessed by Social Services to check for unmet psychosocial needs caused by the noted staff treatment. Any noted problems were corrected and care plans were update as needed. **2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All residents that require assistance with toileting and assisted at meals have the potential to be effected in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 241	Continued From page 6 Findings include: Review of the facility policy titled "Resident-Assisted Dining" occurred on 02/25/10. This policy, dated 11/09, stated, ". . . 5. Encourage resident in feedng self, assisting as needed, following care plan approaches. . . . 7. Have resident wipe lips and clean face, as necessary and able. . . ." - Observation of care for Resident #5 occurred on 02/23/10 at 11:05 a.m. with certified nursing assistants (CNA) (#11) and (#12). The CNAs transferred Resident #5 from her wheelchair to bed using a hoyer lift. The CNAs then removed Resident #5's pants and brief and positioned her back into the sling for the full body lift. When the CNAs raised Resident #5 to a suspended position, approximately two feet, over the bed, Resident #5 began voiding onto the bed. The CNAs questioned the resident's awareness of her voiding. The resident expressed concern about not wanting to get the bed wet. The CNAs reassured the resident and positioned a brief beneath the resident. The CNAs did not lower the resident to the bed or place the brief to allow continuation of the resident's transfer to the toilet, leaving the resident to void in an undignified manner while being suspending in the air. CNA (#11) stated, "That's what happened this morning." When interviewed on the morning of 02/24/10, the CNA (#11) confirmed this statement meant the resident voided onto the bed from a suspended position. When interviewed on 02/24/10 at 8:20 a.m. and 4:45 p.m., an administrative nursing staff member (#4) stated CNAs "should have lowered resident to the bed" or "had pad/brief in place to go to the toilet." This staff member stated, "No one likes to void in	F 241	this area. By educating staff on proper transfer technique and proper assisted dining technique all residents will be protected. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** All Nursing Staff have been educated on March 30, 2010 on Dignity and respect with a focus on toileting assistance and proper technique for assisted dining. **System Change:** Each meal a Charge Nurse will be assigned to monitor the residents' requiring assistance to ensure the dining process if being followed with proper technique. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** Social Service/Designee will audit meal service on a weekly basis to make sure proper assisted dining technique is used. Staff Development/Designee will audit nursing staff on providing dignity during transfers to make sure proper technique is used. Results	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 241	Continued From page 7 bed." - Random observations revealed Resident #2 sitting at an assisted table in the dining room during all meals. In addition, the following observations were made: * On 02/22/10 at 5:35 p.m., a Certified Nurse Assistant (CNA) (#14) fed Resident #2. * On 02/23/10 at 8:15 a.m., a Restorative Aide (#12) fed Resident #2. * On 02/23/10 at 12:00 p.m., a Management Nursing Staff Member (#4) fed Resident #2. During each observation, Resident #2 demonstrated loss of pureed foods from her mouth. More pureed foods ran down her face with each bite of food presented. During each observation, the facility staff member wiped the resident's face after she had taken approximately three-to-five bites and had pureed food running down to her chin, rather than wiping her mouth after each drooling episode. Resident #2's current comprehensive care plan, dated 01/27/10, identified "Problem: Alteration in Nutrition . . . Approaches: Total assist [with] eating." - Observation of the evening meal on 02/22/10 at 5:25 p.m., showed a CNA (#15) used Resident #4's clothing protector to wipe milk from her face, rather than using a napkin. During an interview on 02/25/10 at 10:35 a.m., an administrative nursing staff member (#2) stated she expected staff to use a napkin when wiping the residents' faces during meals. Failure of facility staff to consistently wipe Resident #2's mouth after each episode of	F 241	of the audits will be submitted to the QA/CQI committee on a monthly basis for 3 months. Audits will then continue as directed by the CQI/QA Committee. 5. April 5, 2010 See Addendum to the PoC dated 5/4/10 KS 5/4/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 241	Continued From page 8 drooling and failure to utilize a napkin for Resident #4 does not allow these residents to eat in a dignified manner.	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE COMPLAINT SURVEY COMPLETED ON October 8, 2009. Based on individual resident interview and a resident group interview, complainant information, review of Resident Council meeting minutes, record review, and staff interview, the facility staff failed to act (in a timely manner) upon grievances voiced by the facility's organized Resident Council, for 2 of 2 Resident Council meetings prior to the survey. Failure to act upon the grievances did not recognize the residents' individuality, their right to make choices, or their right to timely resolution of grievances. Findings include: - On 02/22/10 at 5:40 p.m., the facility's Resident Council president gave permission for review of the minutes of the Resident Council Meetings. Review of these meeting on 02/23/10 identified the following:	F 244	F244 Listen/Act on grievance and recommendations of a group **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Social Service visited with Resident #16 and her concern was addressed. Social Service visited with resident #7 and her concern was addressed. Their care plans have been updated based on these visits. **2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** Residents that express concerns have the potential to be effected in this area. Social Service reviewed the minutes from January and February and addressed all concerns brought up during the meetings. Residents who voiced concerns were informed of the plan put in place to address his/her concern.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 244	Continued From page 9 * 01/06/10 - Resident #16 "asked why she had to wait so long for help when on the toilet and [staff member #17] said she would find out for her . . . [facility volunteer] introduced herself and told residents that she had complaints about residents not getting hair fixed and residents not being toileted in a timely manner . . ." * 02/03/10 - Resident #7 "said that water is in little glasses on the tables now instead of larger glasses and she wondered why that was. [Staff member #17] said that she would find out. [Resident #7] also said that toast was burned for supper . . . and that vegetables were too watery and made her bread soggy. She asked if the vegetables could be put in a small bowl instead and [staff member #17] said that she would find out. . ." A resident group interview occurred on 02/23/10 at 1 p.m. with residents the facility identified as interviewable. When asked if the residents felt comfortable voicing concerns, all residents indicated "yes." When asked if they received feedback regarding their concerns, the residents indicated "no." During interview on the afternoon of 02/24/10, a social service staff member (#17) provided a "Resident/Family Concern Log" for January and February, 2010. These logs identified the above concerns addressed at resident council and indicated the issues were resolved, but they did not contain information to show the residents were given an explanation of the resolution. Two "Suggestion or Concern" forms were also provided by the social service staff member	F 244	**3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** Social Service will provide education on 4/5/10 to the Director of Nursing, Activity Director and Administrator on the Complaint process and procedure for Resident Council. Education will include the need to follow up with the person voicing the concern. **System Change:** The Social Worker will be responsible to track and follow up on any grievances using the Grievance Tracking Log. The Activity Director is responsible in the absence of the Social Worker. The tracking log will include follow up with the complainant. The current menu system was reviewed, updated as needed and approved by the facility's Registered Dietician. The revised menu was presented to the Resident Council for their review by the Social Worker.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 244	Continued From page 10 (#17). One form, dated 01/06/10, addressed the concerns brought up during the January resident council meeting. The section titled "Follow up Comments/Reviewed with Concerned Party:" stated, "The audit produced satisfactory results. Staff to be fixing hair." The form dated 02/03/10, addressed the concerns brought up during the February resident council meeting. The section titled "Follow up Comments/Reviewed with Concerned Party:" remained blank. - During an interview on 02/23/10 at 1:40 p.m., Resident A's family member stated, "There are so many sandwiches served in the evenings. It says right on [Resident A's] chart that he/she doesn't like sandwiches." The family member also stated that he/she had spoken with both facility administrative and management staff about his/her dietary concerns, and had received no follow-up. He/she stated, "I feel like the concerns we bring up are falling on deaf ears." On 02/24/10 at 8:40 a.m., when asked what the facility served Resident A for supper the previous evening, the Dietary staff member (#7) stated, "I served [Resident A] a turkey sandwich and beets. She didn't eat any of it. The CNA came up to the window to get her something else." Resident A's Diet Care, obtained from Dietary staff on 02/24/10 at 8:45 a.m., identified "DISLIKES: . . . SANDWICHES . . ." - During an interview on 02/23/10 at 12:10 p.m., Resident #8 stated the facility fails to follow through with concerns brought to their attention. She will bring a concern to a staff member but feels as though no one listens, as she never hears of any actions taken or receives any	F 244	**4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** An audit tool will be developed for to monitor the documentation and follow up on all grievances. A monthly audit of the Grievance Tracking Log will be completed by the Social Worker/Designee. The Social Worker/Designee will be responsible for the completion of the audit and submitting a monthly summary of the audits to the QA/CQI Committee for further recommendations. 5. April 5, 2010 See Addendum to the PoC dated 5/4/10 KS 5/4/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 244	Continued From page 11 feedback. Resident #8 stated she feels it is a problem in general, but some specific examples given included: telling staff she dislikes applesauce but she still receives it; asking staff who she needs to talk to about getting some of her jewelry out of the facility's locked box and never receiving a response; and requesting staff to update her on her husband's health status upon hospitalization, and having to wait hours to receive an update. During interview on the morning of 02/25/10, a social service staff member (#17) indicated she does not always get back in contact with the residents to explain what was done to correct any grievances brought to the attention of the facility.	F 244		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy/procedure, and staff interview, the facility failed to provide reasonable accommodations of individual needs regarding call light access (Resident #3) and assistance with meals (Resident #5 and #6) for 3 of 12 sampled residents. Findings include:	F 246	F246 Accommodation of Resident Needs **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #3's individual needs have been met by placing a pressure pad call light and updating the care plan. Resident #5's individual needs have been met by providing a lipped plate and updating the care plan. Resident #6 individual needs have been met by providing additional assistance and adaptive dining devices for use during meal times and updating the care plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 246	Continued From page 12 The facility's policy, "Assistive Devices," revised March 2009, stated, "Policy: The center will provide special eating equipment and utensils for residents who need these items. Procedure: 1. The rehabilitation nurse or designee, in conjunction with the director of dietary services, may make recommendations regarding resident use of assistive devices. 2. Every effort will be made to assist a resident in attaining/maintaining independence in eating. . . .7. Use of these devices will be noted on the care plan and dietary card. . . ." - Review of Resident #3's medical record occurred on February 22-25, 2010. Diagnoses included: degenerative joint disease, glaucoma, recurrent erosion of the left eye, vascular occlusion to the right eye, dementia, and polymyalgia rheumatica. The Annual Minimum Data Set (MDS), dated 02/18/10, identified Resident #3 with a short term memory problem, moderate impairment with daily decision making, and highly impaired vision with side vision problems. The MDS identified the resident required total dependence of one staff member for bed mobility and toilet use, and required extensive assistance of one staff member for transfers and personal hygiene. The MDS, dated 02/18/10, identified Resident #3 with partial loss of functional limitation in range of motion bilaterally to her arms, hands, legs, and feet. The MDS further identified the resident as frequently incontinent of bowel and bladder. Resident #3's current comprehensive care plan, dated 12/09/09, stated "PROBLEM: Impaired vision r/t [related to] glaucoma, recurrent erosion OS [left eye] m/b [manifested by] lights hurt eyes,	F 246	**2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All residents' that use adaptive equipment have the potential to be effect in this area. Nurse Managers/Designees have reviewed care plans to make sure residents who need adaptive devices for dining have the devices provided. Nurse Managers/Designees have observed all three meal services to check for any residents who may need additional assistance with dining and to make sure any assistive devices are being used. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** Nursing staff will be educated on March 30, 2010 on the procedure for assistive devices. The need for staff to assist in the identification of assistive devices for residents that are having dining difficulties, to have an individual care plan, and to list the equipment on the resident's tray card. Dietary staff have been educated on 4/5/10. The dietary staff received education on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 246	Continued From page 13 dry eyes, limited vision to left eye. And occulsion [sic] to right eye m/b very limited vision. GOAL: Will continue to see light/shadows [and] movement. APPROACHES: . . . Has pressure pad call light. Needs to have call light within reach." Observation on all days of survey showed the facility failed to provide a pressure pad call light to Resident #3. Each observation showed a standard call light attached to the left upper side rail of Resident #3's bed. During an interview on 02/23/10 at 4:30 p.m., a certified nursing assistant (CNA) (#15) stated Resident #3 utilized a pressure pad call light in the past. The CNA stated Resident #3 rarely used the present standard call light. During an interview on 02/24/10 at 8:00 a.m., an administrative nursing staff member (#3) stated the CNAs told her Resident #3 occasionally used the present call light. The nursing staff member (#3) stated she asked Resident #3 to push her call button this morning, but stated it seemed as if the resident was unable to comprehend the request and failed to push the call light button. - Observation of Resident #6 at meals on 02/22/10 at 5:30 p.m. and on 02/23/10 at 11:40 a.m. and 5:20 p.m., showed the resident placed food [beef stroganoff or salmon] on his utensil and as he moved it to his mouth dropped the food on his cover up and the floor. The resident used his utensil to remove food from his cover up to his mouth or moved food to his mouth with his fingers. Observation on 02/23/10 at 5:20 p.m., showed staff served the resident barbecue chicken on a bun. The resident consumed the uncut chicken breast coated with a barbecue	F 246	procedure for assistive devices and to list the assistive device on the residents' tray card. **System Change:** Each meal a Charge Nurse will be assigned to monitor the assistive dining process in the dining room to make sure nursing staff follow proper technique. On 3/23/10 all staff were educated during an all staff meeting on the need to help identify residents who may need additional help in order to have his or her needs met. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** Social Service/Designee will audit meal service on a weekly basis to make sure proper assisted dining devices and technique are used. Staff Development/Designee will audit to make sure proper assistive devices are being used for resident care. Results of the audits will be submitted to the QA/CQI committee for further recommendations. 5. April 5, 2010 See Addendum to the PoC dated 5/4/10 KS 5/4/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 246	Continued From page 14	F 246		

sauce with his fingers. The resident frequently wiped his fingers on a napkin throughout the observation. These observations showed facility staff provided no assistance with cutting Resident #6 chicken breast on a bun, prior to serving the evening meal, or attempted to assist the resident to eat during the observed meals.

Resident #6's current care plan, dated 02/09/10, stated a problem of "Potential for alteration in nutrition . . . increased cueing needed to eat" and an approach of "Feeds self [with] set-up. Assist as needed."

Resident #6's diet card, used in serving the resident's tray, did not include the resident's set up needs.

When interviewed on 02/24/10 at 8:20 a.m. and 5:15 p.m., an administrative nursing staff member (#4) stated facility staff should have cut up Resident #6's meat before serving the meal and staff should be watching residents eat at meals and report concerns to the charge nurse or unit manager for action.

When interviewed on 02/24/10 at 5:00 p.m., a consultant occupational therapist (#13) stated she had reviewed the dining room residents the previous week for acceptable table height. She had not screened for feeding concerns. After this surveyor shared the above observations, this staff member stated an "evaluation would definitely be appropriate," and would look at the resident closely as might be a need for assistive devices such as adaptive silverware or a plate.

- Observation at the evening meal on 02/23/10 at 5:20 p.m., showed staff served Resident #5 her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 246	Continued From page 15	F 246		

meal on a regular plate. Observation at the previous noon meal on 02/23/10 at 11:40 a.m. showed the resident received her meal on a lip plate.

Resident #5's current care plan, dated 01/25/10, stated a problem "Potential for alteration in nutrition" and the approach, dated 02/04/10, "Lip plate [plate with deep inner lip] for meals."

When interviewed on 02/24/10 at 5:55 p.m., a dietary staff member (#16) stated, "I know the assistive devices" used by residents and began listing examples. This staff member then showed this surveyor the area on the diet card used for assistive devices. Resident #5's diet card did not include the use of a lip plate.

During an interview on 02/25/10 at 9:50 a.m., an administrative dietary staff member (#8) stated she did not implement assistive devices. The restorative nurse initiated assistive devices based on an occupational or physical therapy evaluation or a nurse if he/she observed concerns during a meal. This staff member stated she had not received communication regarding Resident #5's need for a lip plate. This staff member stated the lip plate "should have been written on the diet card" and facility staff serving the resident should review the diet card for accuracy.

When interviewed on 02/24/10 at 8:20 a.m. and on 02/25/10 at 8:30 a.m.., an administrative nursing staff member (#4) stated at the noon meal on 02/23/10 dietary staff had not provided Resident #5 with a lip plate. When she observed this, she redirected dietary staff to provide the resident with a lip plate. This staff member stated she would attempt to locate the communication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 246	Continued From page 16 form sent to dietary regarding Resident #5's need for a lip plate. This staff member provided no additional information.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide an ongoing program of activities for 1 of 5 sampled residents (Resident #2) severely impaired in daily decision making and requiring total assistance for activities of daily living. Activities are an integral component of residents' lives and failure to implement an individualized activity program to respond to the interests and current capabilities of this resident has the potential to affect her physical, cognitive and emotional health. Findings include: Random observations showed the following: * 02/23/10 at 7:50 a.m., 8:45 a.m., 9:05 a.m., Resident #2 sat in her tilt-in-space wheelchair in the hallway near the nurses' station. * At 9:15 a.m., The CNA (#23) transferred Resident #2 from her wheelchair to her bed. After lying the resident down, the CNA (#23) asked her if she would like to attend mass. She shook her head 'No.' The CNA (#23) did not offer to turn on music or the TV before leaving the room.	F 248	F248 Activities **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #2's activity programming was reviewed by the Activity Director and resident #2's family. Modifications to the care plan were made and activity staff educated. **2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All resident that need 1to1 visits for activity have the potential to be effected in this area. Activity Director/Designee reviewed the activity plan for all lower functioning residents to make sure the residents' activity needs are being met. Care plans were updated and activity staff educated. **3. This is what the facility will do or changes it will make to the systems that**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 248	Continued From page 17 * At 10:15 a.m. and 11:00 a.m., Resident #2 remained in bed. Her room remained silent. * At 12:45 p.m and 2:50 p.m., Resident #2 sat in her wheelchair in the hallway near the nurses' station. Facility staff did not interacted with Resident #2 throughout either observation. * At 4:15 p.m., Resident #2 remained in her wheelchair while her mother spent time with her. Review of Resident #2's medical record occurred on February 22-25, 2010. The facility admitted the resident in August, 2007. Medical diagnoses included: depression and profound mental retardation. Resident #2's quarterly Minimum Data Set (MDS), dated 01/22/10, identified severely impaired daily decision making skills, total assist with all activities of daily living (ADLs), and activity preferences of music, walking/wheeling outdoors, and tv. Resident #2's current Comprehensive Care Plan, dated 01/27/10, identified ". . . Problem: Impaired Social Interaction . . . Approaches: 1-to-1 visits with resident 5 x's [times] a week for stimulation with soft touch, calming voice, or stuffed animal as she tolerates, Escort resident in reclined w/c [wheelchair] to activities of interest to observe like: music, watching people, watching birds, church services, and physical games . . . Sensory group (i.e. soft touch items) as available. . . ." Resident #2's Physician Orders, dated 02/09/10, identified, "Activity program as tolerated." Resident #2's Activity Participation Record, dated 12/01/09 - 02/23/10, identified the following: * December 2009 * No activies on 8 of 31 days * 1:1 only activity of day on 6 of 31 days	F 248	**will prevent this problem from reoccurring in the future.** The Activity Director has received additional education on 4/5/10. Education was provided on how to meet the needs of lower functioning residents. The Activity Director/designee will review all residents that need one to one visits for activities on a weekly and follow up as needed. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** An audit tool will be developed to monitor the activity participation report for residents that require 1 to 1 visits for activities. The Activity Director/designee will complete the audit and report to the QA/CQI committee on a monthly basis that shows a weekly participation record review of all lower functioning residents was completed. The results of the audits will be reported to the QA/CQI committee for further recommendations and action needed to ensure compliance in this area. 5. April 5, 2010 See Addendum to the PoC dated 5/4/10 KS 5/4/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 248	Continued From page 18 * January 2010 * No activities on 5 of 31 days * 1:1 only activity of day on 5 of 31 days * No activities on 11 of 24 weekend days (Saturday or Sunday) During interviews on 02/24/10 at 10:10 a.m. and 02/25/10 at 9:15 a.m, a management Activity staff member (#25) stated, "Activities are attended by those who are interested. Those who don't attend are either sleeping, lying down, getting medication, being toileted, or at a doctor's appointment." He further stated, " 'One-on-one visits' mean we talk to her. Typically we talk to her 3 times a day. Combined, that amounts to 5-to-10 minutes in a day. If she is in her chair in the hallway or in her room, we bring her down [to activities]. 'Unable to attend' means she was in bed. If she is in bed, we don't [bring her down]. They [CNAs] know the activity schedule and her preferences. They [list of preferred activities] are in their palm pilots. If we don't bring her down, it is the CNAs' job to bring her to the activity." The facility staff failed to provide a meaningful activity program responsive to Resident #2's profound mental and physical handicaps.	F 248		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F309 Providing Care and Services **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #1 was re-assessed for bowel care and her care plan was updated. Resident #2 was re-assessed and appropriate positioning and the care plan was updated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 309	Continued From page 19 This REQUIREMENT is not met as evidenced by: 1. Based on record review, resident interview, staff interview, review of facility policy and procedure, and review of professional literature, the facility failed to ensure 1 of 3 sampled residents (Resident #1), with a diagnosis of constipation and identified by the facility as having experienced a fecal impaction, received effective interventions to maintain normal bowel elimination patterns to prevent constipation and/or fecal impaction. This failure resulted in Resident #1 experiencing discomfort and being hospitalized. Findings include: Berman, Snyder, Kozier, Erb, "Fundamentals of Nursing, Concepts, Process, and Practice," 8th edition, Pearson Education, Inc., New Jersey, pages 1212, 1328-1329, stated: * "Constipation may be defined as fewer than three bowel movements per week. This infers the passage of dry, hard stool of the passage or no stool. . . . Many causes and factors contribute to constipation. Among them are the following: Insufficient fiber intake, Insufficient fluid intake . . . Irregular defecation habits . . . Medications such as opioids . . ." * "Sample Defining Characteristics for Constipation: Decreased frequency of defecation, Hard, dry, formed stools . . . Abdominal pain, cramps, or distention, Anorexia, nausea . . ." * "Common Opioid Side Effects, Preventive, and Treatment Measures: Constipation: Increase fluid intake . . . Increase fiber and bulk-forming agents to the diet . . .Administer daily stool softeners combined with a mild laxative . . . as a first line of prevention against constipation for clients on opioid maintenance therapy . . . Stimulants . . .	F 309	**2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All resident with the diagnosis of constipation have the potential to be effected in this area. The DNS/Designee reviewed 100% of the residents with the diagnosis of constipation and receive a regularly scheduled opioid will have their bowel assessment reviewed and revised and care plans updated as needed based off of the assessment. The DNS/Designee reviewed 100% of the residents at risk for aspiration due to difficulty swallowing. Any needed changes were made and care plans updated. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** Nursing staff were educated on March 30, 2010 on the bowel care policy and on charting bowel movements. **System change:** A report has been developed and the licensed nurses were educated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 309	Continued From page 20 osmotic laxatives . . . and enemas . . . and even prokinetic agents . . . may be needed for refractory cases of constipation . . ." * "Fecal impaction is a mass or collection of hardened feces in the folds of the rectum. Impaction results from prolonged retention and accumulation of fecal material. . . . Along with fecal seepage and constipation, symptoms include frequent but nonproductive desire to defecate and rectal pain. A generalized feeling of illness results; the client becomes anorexic, the abdomen becomes distended, and nausea and vomiting may occur. . . ." Review of the facility policy titled "Bowel Assessment" occurred on 02/25/10. This policy, dated November 2009, stated, * "Assessment: . . . 3. After the 72-hour observation has been completed, the Bowel Assessment . . . should be completed for residents who are incontinent or who have problems with elimination such as constipation or a history of impactions or a change in condition which affects elimination patterns. . . . 4. Use the following assessment data to determine the need for a program: . . . b. Bowel History: Consider past and present bowel history. Look at . . . stool characteristics (i.e., consistency, color); frequency . . . episodes of constipation . . . impaction . . . c. Nutritional History: . . . fiber and fluid adequacy . . . d. Functional Ability: . . . assistance for bowel management . . . e. Medications: What has been used in the past and what presently can be causing bowel problems (i.e., pain medications). * " Possible Interventions and Modifications: . . . 1. Plan interventions based on the individual resident and assessment: a. Diet: Add fiber to the diet . . . b. Fluid intake: Two to three quarts of fluid daily . . . g. Medications . . . h. Bowel	F 309	on the need to produce a report that will help them to identify residents who may be at risk of constipation. This report will be reviewed by the nursing staff and any concerns will be addressed. Copies of the report and interventions taken will be forwarded to the Nurse Managers the next working day for their review. Nursing Staff were educated on the dysphasia policy and procedure. **System Change:** At each meal a Charge Nurse will be assigned to monitor the assistive dining process and will also monitor to residents who may be at risk for aspiration. Any problems during the meal service will be addressed immediately and appropriate follow up completed. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** Health Information Management will audit 10% of the residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 309	Continued From page 21 Program Modifications . . ." Review of Resident #1's medical record occurred on February 22-25, 2010. The facility admitted the resident in June, 2008. Medical diagnoses included: constipation, decreased appetite, peptic ulcer disease, history of uterine cancer, radiation, chemotherapy, depression and lower back pain. Resident #1's quarterly Minimum Data Set (MDS), dated 09/18/09, identified moderate independence with making daily decisions, continence of bowel, and moderate pain daily. Resident #1's significant change Minimum Data Set (MDS), dated 12/19/09, identified bowel elimination pattern regular - at least once every 3 days, constipation, fecal impaction and enemas/irrigation. Resident #1's quarterly Minimum Data Set (MDS), dated 12/28/09, also identified fecal impaction. Resident #1's Bowel Assessment, dated 12/28/09, identified the resident had a "bowel movement two-to-three times weekly," "no pattern" existed, a "hx [history] of impaction," prescribed "laxatives and enemas," and recommended "increased [water intake]." Resident #1's Medication Administration Record (MAR), dated 11/01/09 - 12/06/09, identified the following: * Darvocet (pain medication) PRN [as needed]: administered one-to-three times daily on 11/02/09, 11/04/09 - 11/21/09, 11/23/09, 11/25/09 - 12/05/09 * Metamucil (fiber): administered daily * Milk of Magnesia PRN and Bisacodyl Supp (laxatives) PRN: not administered The Nursing 2009 Drug Handbook, 29th Edition,	F 309	every month, checking to make sure appropriate bowel and dysphasia protocols are in place. . Results of the audits will be submitted to the QA/CQI committee on a monthly basis for 3 months. Audits will then continue as directed by the CQI/QA Committee. 5. April 5, 2010 See Addendum to the PoC dated 5/4/10 KS 5/4/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 309	Continued From page 22 p.762-763, identified Darvocet as having ". . . adverse GI [gastrointestinal] effects including. . . constipation . . ." Resident #1's Interdisciplinary Progress Notes identified the following: * On 12/05/09 at 4:45 p.m., Resident #1 began experiencing abdominal tenderness and pain, lack of bowel sounds, and emesis. The facility administered Darvocet and Riopan. At 7:50 p.m., the facility notified her physician and sent her to the emergency room. She returned to the facility at 10:20 pm. * On 12/06/09 at 2:00 a.m., the facility administered Darvocet. Resident #1 continued to experience restlessness during the night, emesis, and abdominal pain. The facility administered Zofran at 10:00 a.m. Resident #1 continued to experience emesis, abdominal tenderness and pain, and faint bowel sounds in one quadrant only. At 11:00 a.m., the facility notifed the on-call physician and sent her back to the hospital. The Hospital Discharge Summary, dated 12/15/09, identified "[Resident #1] was admitted to the hospital for further management because of her evident small bowel obstruction." During an interview on 02/22/10 at 5:35 p.m., Resident #1 (whom the facility identified as being interviewable) stated, "They took me to the ER. They gave me an enema and cleaned me out. . . . I had requested a stool softener, but my Dr. [doctor] said, 'No. I didn't need it'." Resident #1's Nutritional Assessment, dated 12/22/09, identified "Hospital return: 83 y o [year old] female [with] recent hospitalization for N/V [nausea and vomitting] . . . appetite remains poor	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 309	Continued From page 23	F 309		

. . . will add to nutritional risk [and] monitor . . ." The Nutritional notes for Resident #1 lacked any reference to her constipation and/or approaches/interventions to assist her in maintaining normal/regular elimination patterns.

Resident #1's Care Plan, dated 09/11/09 - 01/22/10, did not identify concerns regarding constipation. The facility did not list any nursing or dietary approaches on her care plan to prevent the side effects of prescribed pain medications even though she was at risk for constipation.

During an interview on 02/24/10 at 9:45 a.m., an administrative nursing staff member (#2) stated, "I would expect my staff to look at the side effects [of pain medications] and put a plan in place to prevent those side effects. If the resident was at risk for constipation, we'd get with dietary, the CNAs, restorative therapy and/or physical therapy." She further stated, "She [Resident #1] self toilets. She couldn't remember if she had a bowel movement or not. Charting hasn't been effective. She couldn't remember if she remembered to mark it [chart]. We talked about locking [shutting off the water to] the toilet. I have to agree with you, we did not care plan for risk of constipation." The administrative nursing staff member (#2) agreed the record showed no evidence the facility put a plan in place to prevent the side effects of prescribed pain medications.

Following readmission to the facility, on 12/15/09, Resident #1's MAR, dated 12/15/09 - 01/09/10, identified the following:
* Darvocet PRN: administered one-to-three times daily on 12/15/09 - 12/17/09, and discontinued 12/18/09
* Ultram (pain medication) PRN: administered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 309	Continued From page 24	F 309		

one-to-two times daily 12/15/09 - 12/16/09 and 12/18/09, and discontinued 12/18/09
* Morphine (pain medication) PRN: administered daily 12/18/09 - 12/21/09 and 12/24/09 - 12/28/09
* Fentanyl (pain medication): administered 12/30/09, 01/01/10, 01/04/10 and 01/07/10, and dose decreased by half 01/09/10
* Bisacodyl Supp PRN: administered on 12/18/09 . . . "To promote BM . . . Lg BM" . . . and on 01/04/10 . . . "Given for bowel stimulation"
* Milk of Magnesia PRN: administered on 01/05/10 . . . "[No] stool" and on 01/06/10 . . . "To promote stool"

The Nursing 2009 Drug Handbook, 29th Edition, p. 744-746, 753-754 and 762-764, identified:
* Ultram as having ". . . Adverse Reactions: . . . GI: . . . constipation . . ."
* Morphine as having ". . . Adverse Reactions: . . . GI: . . . constipation . . ."
* Fentanyl as having ". . . Adverse Reactions: . . . GI: . . . constipation . . ."

Following readmission to the facility on 12/15/09, Resident #1's Interdisciplinary Progress Notes identified the following:
* From 01/03/10 at 6:30 a.m. to 01/07/09 at 9:30 a.m., Resident #1 experienced emesis, lack of appetite, sluggish bowel sounds, and nausea.
* On 01/09/10 at 7:00 a.m., Resident #1 continued to experience nausea and lacked sleep.
At 11:56 a.m., the facility notified the on-call physician and sent her to the emergency room to be evaluated. She returned to the facility at 10:20 p.m. The facility administered Fentanyl. At 7:55 p.m., the resident's daughter reported that she continued to experience emesis. At 8:00 p.m., the facility notified the physician and sent her back to