STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, resident interview, group interview and record review, it was determined the facility failed to honor resident choices regarding dietary likes and dislikes for 1 of thirteen sample residents (#4) and for residents present in group interview with survey team, creating the potential for poor dietary intake and weight loss. The findings included: 1. Review of the medical record for sample resident #4 revealed the resident was admitted to the facility on 8/7/07 with multiple diagnoses including mental retardation, stiffness of lower extremities, gastroesophageal reflux and arthritis. a. The resident's diet card indicated the resident was on a puree diet. This card also listed the resident's food dislikes which included beets. b. Observation of the evening meal served to the resident on 4/6/10 demonstrated the resident was not served his/her ordered diet or that the resident's dislikes were honored. The resident received a regular diet with chicken noodle casserole and beets. An alternate meal tray was	F 242	**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 242 Honor resident choices regarding likes and dislikes** **1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ronald D Hedges — TITLE: Administrator — (X6) DATE: 04/26/2010

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 242	Continued From page 1 requested for the resident. c. In an interview on 4/6/10 at 6:00 PM with the resident's family member she indicated the resident was unable to eat the meal (was not the ordered puree diet) and confirmed the resident did not like beets. 2. On 4/7/10 at 10:45 AM, during the Group Interview with five residents present, the residents voiced complaints about the facility not honoring resident choices regarding dietary likes and dislikes. The residents' voiced concerns included: "They ask you what you want but they still bring you food you don't like." "They keep bringing things you don't like." "It is like they don't listen to you." "We use to get a copy of the menu and the alternates for the week so we had a choice but we don't get those anymore. A lot of times we don't know what the alternate is." 3. During a confidential resident interview on 4/8/10 at 9:15 AM, a resident reported that he/she was asked about the foods he/she liked or disliked. However, he/she keeps getting served foods he/she doesn't like. The resident reported that the diet card is supposed to tell staff what residents don't want but "it is like getting ignored."	F 242	Resident #4's individual concerns have been addressed by clarifying her diet order with his physician. Resident #4, family, and caregivers have been interviewed and resident food preferences updated. Diet card and care plan have been updated. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action (s) will be taken:** The Interim Director of Dietary Services (DDS) met with the Resident council president on April 20, 2010 to discuss menu concerns and food preferences. An audit of diet order, food inventories, and care plans were completed for all residents and diet cards updated as of 5-10-10	
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive	F 246	**3. What measures will be put into place or what**	

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F 246	Continued From page 2 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, staff interview and resident/group interviews, it was determined the facility failed to respond to call lights in a timely manner creating the potential for unmet resident needs. The findings included: 1. Observations of the hallways in the facility during all days of the survey revealed nursing staff, nurses and certified nurse aides (CNAs) walking by rooms where the residents had turned on their call light for assistance. a. On 4/6/10 at 4:00 PM the call light in room 310 was observed to be on. Two unidentified nursing staff members (nurse and certified nurse aide) were observed walking by the room but did not go into the room to assist the resident. The call light was subsequently answered at 4:20 PM. b. On 4/7/10 at 9:00 AM the call light in room 204 was observed on and an unidentified CNA was observed walking by the room without offering assistance to the resident. The call light was subsequently answered by another CNA at 9:05 AM. 2. On 4/6/10 for several minutes starting at 3:15 PM, a call light was on in the 400 hallway. CNA	F 246	**systemic changes will you make to ensure the deficient practice will not recur:** A system is in place to ensure that resident like and dislikes are honored and food preferences are updated routinely. An in-service was conducted on 5-10-10 for all dietary staff on accuracy in meal service utilizing the diet card information to accommodate likes and dislikes. A mandatory in-service for licensed nurses will be held 5-10-10 on diets available in the center and updating the care plan. **4. Indicate how the center will monitor its performance to make sure the changes sustained. Indicate how the changes are integrated into and evaluated by the quality assurance program:**	

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F 246	Continued From page 3 (C) was observed to walk past the room several times without entering the room to assist the resident. The nurse (D) was observed to enter the room and the call light was turned off. 3. On 4/9/10 at 8:40 AM, in an interview with a resident, the resident revealed that he/she has had to wait long times for staff to come. The resident verified that so far he/she has not been incontinent from the waiting. 4. On 4/6/10 during a confidential interview, a resident reported that it takes staff a long time to answer call lights. 5. On 4/7/10 at 10:45 AM, during the Group Interview with five residents present, the residents voiced complaints about call lights not getting answered timely. There were four of five residents who voiced concerns which included: "Call lights are not answered timely.", "It takes a long time to get help. I have waited an hour on the toilet", "Close to mishap (incontinence) due to wait." 6. Review on the "Resident Council Minutes" identified concerns with call lights which included: 1/6/2010 identified issues with call lights and wait long time on the toilet. 7. Interview with the DON (Director Of Nursing) on 4/8/10 at 4:00 PM confirmed she was aware of	F 246	The DDS will conduct a random audit of tray card and meal service accuracy weekly for 4 weeks, then monthly x 3. The results of the audits will continue and will be reported to the QA/CQI committee for 3 months and then as directed by the QA/CQI committee. 5. **Date when corrective action, (substantial compliance), will be completed:** 5-16-10 **F246 Reasonable accommodation of needs/preferences** 1. **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** All residents call lights are being answered timely.	

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F 246	Continued From page 4 resident complaints about call lights not being answered timely. She reported that the Certified Nurse Aide communication book addressed that call lights were to be placed in reach and answered timely. There was no evidence of follow up with the residents ongoing concerns with call lights not being responded to timely.	F 246	**2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action (s) will be taken:** All residents that can use the call light have the potential to be affected in this area and Call lights will be monitored for appropriate response times. **3. What measures will be put into place or what systemic changes will you make to ensure the deficient practice will not recur:** An all staff meeting will be held on 5-10-10 to educate the staff on responding to call lights and checking on residents. If appropriate, staff will help the resident or find a staff member qualified to help the resident.	
F 274 SS=E	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: A significant change as defined in the Long Term Care Resident Assessment Instrument (RAI) User's Manual, updated by the Centers For Medicare & Medicaid Services (CMS) in December, 2002, is "a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard	F 274		

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F 274	Continued From page 5 disease-related clinical interventions, is not 'self-limiting'; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan." "A significant change assessment is appropriate if there are either two or more areas of decline or two or more areas of improvement." A Significant Change in Status assessment is to be done "No later than: 14 days following determination that a significant change has occurred." Based on staff interview and record review, it was determined the facility failed to conduct a comprehensive assessment of residents within 14 days when a significant change occurred in the resident's condition (improvement or decline) for five of thirteen sample residents (#5, #11, #1, #12, and #8) creating the potential for unidentified and unmet resident needs. The findings included: 1. Review of the medical record for sample resident #1 revealed the resident was admitted to the facility on 6/14/08 with multiple diagnoses including COPD (Chronic Obstructive Pulmonary Disease), Congestive Heart Failure, hypertension, and constipation. a. The resident was admitted to the hospital in December 2009 and with his/her return to the facility a significant change Minimum Data Set (MDS) assessment (dated 12/19/09) was conducted. This MDS showed the resident	F 274	**4. Indicate how the center will monitor its performance to make sure the changes sustained. Indicate how the changes are integrated into and evaluated by the quality assurance program:** Staff Development, or designee, will audit the length of time it takes to answer call lights. Five audits will be conducted per week on all three shifts for 4 weeks, then monthly for three months. The audit results will be reported to the QA/CQI committee for further recommendations. **5. Date when corrective action, (substantial compliance), will be completed:** 5-16-10 **F274 Comprehensive Assessment after significant change**	

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F 274	Continued From page 6 required extensive assistance from one staff member for Activities of Daily Living (bed mobility, transfer, dressing, toilet use and personal hygiene). b. A quarterly MDS assessment dated (3/15/10) showed the resident required only assistance with bathing. No significant change (full) MDS assessment was conducted with this improvement of the resident's condition. 2. Review of the medical record for sample resident #12 revealed the resident was admitted to the facility on 10/31/01 with multiple diagnoses including Insulin Dependent Diabetes Mellitus, hypertension, and edema. a. The most current MDS assessments (quarterly dated 2/12/10 and quarterly dated 11/13/09) did not show indications of delirium or behavior symptoms. b. Although the resident had changes in his/her Abnormal Involuntary Movement Scale (AIMS) assessment, required the addition of Cogentin to his/her medication regimen, experienced increased abnormal trunk, extremity and oral/mouth movements causing him/her to cough/choke at meals, required a speech evaluation and was exhibiting signs of Tardive Dyskinesia, no significant change MDS assessment had been conducted. (See F329 for patient specifics). 3. Record review for sample resident #5 revealed that the resident had diagnoses that included macular degeneration, cataracts, hypertension,	F 274	**1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** For residents #5, #11, #1, #12 and #8 individual needs, each residents old comprehensive assessment was compared to the latest MDS assessment. If a significant change occurred, then a significant change assessment will be completed and Care plans will be update as indicated. If a significant correction is needed, then a modification assessment will be completed. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action (s) will be taken:**	

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F 274	Continued From page 7 anxiety, chronic obstructive pulmonary disease, subdural hematoma, insomnia, cardiac disease, and dementia. a. Review of the resident's 1/15/10 quarterly and 10/15/09 MDS assessments evidenced the resident experienced the following improvements without evidence that the facility staff had completed a full, comprehensive re-assessment for this resident to determine if any new care plan approaches were warranted: 10/09 - The resident was assessed as requiring extensive assistance with dressing. 1/10 - The resident was assessed as requiring limited assistance with dressing. 10/09 - The resident was assessed as requiring extensive assistance with bathing. 1/10 - The resident was assessed as requiring limited assistance with bathing. The above changes indicated that a significant change assessment should have been completed for this resident. b. On 4/8/10 at 10:17 AM, in an interview with Certified Nurse Aide (L), she indicated that the resident needs encouragement and reminders to do personal cares. The failure to complete a comprehensive re-assessment when a resident experiences a significant change can result in the care plan not being updated as appropriate for the resident's changed status. 4. Record review for sample resident #11 revealed that the resident had diagnoses that	F 274	All skilled nursing residents have the potential to be affected in this area. All residents' most current MDS and previous MDS will be compared and analyzed to determine is a significant change has occurred. If a change is noted, then a significant change MDS will be started. 3. **What measures will be put into place or what systemic changes will you make to ensure the deficient practice will not recur:** All disciplines completing parts of the MDS have all been educated on the need to complete a change in condition assessment. The Director of Nursing and Nurse Managers/Designee will monitor using 24 hour reports and incident reports for any changes in resident condition to make	

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F 274	Continued From page 8 included pneumonia, anxiety, hypertension, back pain, shortness of breath, and urinary tract infection. Review of the resident's 12/17/09 and 3/17/10 quarterly MDS assessments evidenced that the resident experienced the following declines without evidence that the facility staff had completed a full, comprehensive re-assessment for this resident to determine if any new care plan approaches were warranted: 12/09 - The resident was assessed as requiring limited assistance with bed mobility. 3/10 - The resident was assessed as requiring extensive assistance with bed mobility. 12/09 - The resident was assessed as requiring limited assistance with transfer. 3/10 - The resident was assessed as requiring extensive assistance with transfer. 12/09 - The resident was assessed as requiring limited assistance with walk in corridor. 3/10 - The resident was assessed as not walking in corridor. 12/09 - The resident was assessed as usually continent of bladder. 3/10 - The resident was assessed as occasionally incontinent of bladder. The above changes indicated that a significant change assessment should have been completed for this resident. The failure to complete a comprehensive re-assessment when a resident experiences a significant change can result in the care plan not	F 274	sure require assessment are completed. 4. **Indicate how the center will monitor its performance to make sure the changes sustained. Indicate how the changes are integrated into and evaluated by the quality assurance program:** An audit tool has been developed and completed on all residents looking for significant changes. The audit will be completed on two residents per month for three months with the results of the audit to the QA/CQI committee for further recommendations. The DNS, or designee, is responsible for completing this audit. 5. **Date when corrective action, (substantial compliance), will be completed:** All corrective action will be completed by 5-16-10.	

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F 274	Continued From page 9 being updated as appropriate for the resident's changed status. 5. Record review revealed that sample resident #8 was admitted to the facility on 12/3/03 and readmitted from the hospital on 11/19/09. The resident's diagnoses included: hypertension, glaucoma, polymyalgia rheumatica, DJD (degenerative joint disease), chronic UTI (urinary tract infections), anxiety, depression, and pain. Review of the resident's Minimum Data Set (MDS) assessments showed quarterly assessments done 9/2/09 and 11/25/09. The following areas showed a decline in the resident's status with return from the hospital 11/19/09: 9/2/09 Section G showed bed mobility as 2-2 (limited assistance of one person) 11/25/09 showed bed mobility as 3-2 (extensive assist of one person) 9/2/09 the resident weight was listed as 122 pounds. 11/25/09 the resident weight was listed as 110. This was a 12 pound weight loss and significant weight loss (9%) in 3 months. The MDS did identify the weight change as weight loss (5% or more in the last 30 days or 10% or more in last 180 days). These areas indicated a decline or significant change and required that a comprehensive MDS re-assessment be completed and/or revision of the care plan. The facility failed to complete a full significant change assessment for this resident to determine if any new care plan approaches were warranted.	F 274		

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F 274	Continued From page 10 6. Interview with nurse (M) confirmed an overall decline in the resident's condition with generalized weakness, dysphagia and refusal to eat and pain. [Note The resident's weight recorded on 3/17/10 was 100 pounds, 15.97% weight loss in 180 days.] 7. On 4/6/09 at 4:00 PM, an interview with the DON (Director of Nursing) verified the declines documented on the MDS which warranted a significant change, comprehensive assessment. The DON reported that issues with MDS assessment had been identified and staff had been sent to training. Additionally follow up and assessment would be done for this resident to determine if any new care plan approaches were needed.	F 274	**F 278 Assessment accuracy/coordination/certified** **1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #2's individual needs will be met by changing the admission date on the MDS to match the face sheet. The resident was admitted to the center on 11-24-09. The 14-day MDS from 12/2/09 has been change to reflect a 14- day Medicare MDS and 00 - none of the above was scored for section AA8a. A functional ROM assessment has been completed on resident #2 and the MDS was reviewed for accuracy for section G4. A referral was sent to PT requesting a transfer assessment. This residents'	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278		

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F 278	Continued From page 11 $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: Based on staff interview, observations and record review, it was determined the facility failed to ensure the accurancy of the Minimum Data Set (MDS) assessment for three of thirteen sample residents (#2, #8 and #11), creating the potential for unidentified and unmet resident needs. The findings included: 1. Record review for resident #2 evidenced that the resident had diagnoses that included recurrent urinary tract infections, peptic ulcer, hypertension, osteoporosis, stroke, diabetes, subdural hematoma, depression, and cardiac disease. a. Review of the face sheet in the resident's record listed an admission date of 8/28/09. Interviews with nurses (D and P) verified that the admission date was incorrect and that the resident was admitted on 11/24/09. b. Review of the resident's Minimum Data Set (MDS) assessments revealed the following assessments: 11/28/09 - admission assessment	F 278	transfer status was reviewed and care plan was updated and needed. Resident #8's individual needs will be met by completing a functional ROM assessment and the MDS was reviewed for accuracy for section P4. Care plan was updated. A modification MDS will be sent in for the coding of section G4. This resident was also assessed for a significant change in status. A significant change MDS has been started for this resident. Care plan was updated as needed. Resident #11's individual needs will be met by completing a functional ROM assessment on this resident and the MDS was reviewed for accuracy of section G4 and the MDS was reviewed for a significant change. Care plan was updated as needed.	

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F 278	Continued From page 12 12/2/09 - 14 day Medicare assessment and a quarterly. c. On 4/6/10 at 3:53 PM, in an interview with nurse (G), she stated that she did the MDS assessments, but the input was done by staff member (Q). Nurse (G) called staff member (Q) and was told that she always inputs a quarterly with this type of assessment (Medicare). The incorrect admission date and the 12/09 MDS labelled as a quarterly indicated inaccuracies in the documentation for this resident. These dates could cause assessments to be completed incorrectly. d. Record review of the resident's two assessments revealed that the resident was assessed as having no functional range of motion limitations. e. Observations and staff interviews throughout the survey evidenced that the resident required extensive to total assistance with activities of daily living and was transferred using a total mechanical lift. 2. Record review for sample resident #11 revealed that the resident had diagnoses that included pneumonia, anxiety, hypertension, back pain, shortness of breath, and urinary tract infection. Review of the resident's 12/17/09 and 3/17/10 quarterly MDS assessments evidenced that the resident was assessed as having no functional range of motion limitations.	F 278	**2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action (s) will be taken:** The comprehensive assessments for all residents were reviewed for accuracy. Care plans were updated if needed. **3. What measures will be put into place or what systemic changes will you make to ensure the deficient practice will not recur:** All disciplines completing parts of the MDS have been educated on accurately completing comprehensive assessments. **4. Indicate how the center will monitor its performance to make sure the changes sustained. Indicate how**	

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F 278	Continued From page 13 Observations and staff interviews throughout the survey evidenced that the resident required extensive to total assistance with activities of daily living. 3. Record review revealed that sample resident #8 was admitted to the facility on 12/3/03 and readmitted from the hospital on 11/19/09. The resident's diagnoses included: hypertension, glaucoma, polymyalgia rheumatica, DJD (degenerative joint disease), chronic UTI (urinary tract infections), anxiety, depression, and pain. a. Review of the resident's (MDS) assessments showed quarterly assessments done 9/2/09, 11/25/09 and an annual MDS done 2/18/10. The areas of concern that the MDS did not accurately reflect the resident's status included: 1) The MDS on 9/2/09 and 11/25/09 had Section G 4. "Functional limitation in range of motion" marked as zero indicating no limitation and no loss of voluntary movement. The MDS on 2/18/10 had the same area Section G4. identified as 2-1 (Limitation in ROM both sides with partial loss of voluntary movement). The "Change in ADL function" was identified as 2 (deteriorated). 2) There were two other areas identified as decline or deteriorated, change in mood and weight. Resident weights included: 9/2/09 122 pounds, 11/25/09 110 pounds and 2/18/10 weight listed as 102 pounds. Each MDS identified the weight change as weight loss (5% or more in the last 30 days or 10% or more in last 180 days).	F 278	**the changes are integrated into and evaluated by the quality assurance program:** The DNS/Designee will audit 5 residents per month to make sure the comprehensive assessment is accurate. Results of the audits will be reported to the QA/CQI Committee for 3 months and then as directed by the QA/CQI Committee. 5. **Date when corrective action, (substantial compliance), will be completed:** 5-16-10	

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F 278	Continued From page 14 The 2/18/10 MDS showed multiple areas of decline however the overall change in care was marked as zero (no change). b. On 4/6/09 at 4:00 PM, an interview with the DON (Director of Nursing) verified the declines documented on the MDS which warranted a significant change, comprehensive assessment. The concern with the decline in ROM identified on the MDS was reviewed with the DON who reported that issues with MDS accuracy had been identified and staff had been sent to training.	F 278	**F 280 Right to participate planning care-revise care plan** **1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident # 2 will have their individual needs met by having a referral sent to PT for transfer assessment. The care plan will be updated based on this assessment, her restorative program has been discontinued as this resident no longer ambulates or stands. This resident was reviewed for the potential for burns due to hot coffee. The eye infection has cleared and is not longer being treated and the skin is intact. Care plan has been reviewed and revised as needed. Resident # 2 will have their individual needs have been addressed by sending a PT	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280		

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F 280	Continued From page 15 by: Based on observation, staff interview, family interview, and record review, it was determined the facility failed to revise resident care plans to address the residents's current status and needs, specifically pain management interventions and accident prevention for hot liquid spills for four of thirteen sample residents (#2, #6, #8 and #9), creating the potential for unresolved pain and potential burns. The findings included: 1. Record review for resident #2 evidenced that the resident had diagnoses that included recurrent urinary tract infections, peptic ulcer, hypertension, osteoporosis, stroke, diabetes, subdural hematoma, depression, and cardiac disease. a. Review of the resident's care plan revealed a problem of self care deficit with approaches of "assist of 1 for ADLs" and "Assist with ADLs BID (twice a day)". b. Review of the resident's care plan revealed a problem of mobility impairment with approaches of "RT (restorative therapist) to see 6 X weekly to stand in parallel bars or may walk with walker and ambulate as tolerate." c. Observation of the resident's cares evidenced that the resident was transferred with a total body lift and two staff. d. Interviews with staff and family verified that the resident no longer ambulates or stands. e. Record review evidenced that the resident received second degree burns from spilled coffee in 2/10. There was a temporary care plan for	F 280	referral for transfer assessment. The ID team screened the resident for the potential for hot liquid spills and care plans updated as needed. Resident #9 will have their individual needs met by ensuring the skin is intact and healed from the hot coffee spill. The ID team screened the resident for the potential for hot liquid spills and the care plan was updated as needed. Resident # 8 and #6 will be assessed for pain. If these residents are in pain, their primary care physician will be contacted and any new orders will be processed and their care plan will be updated as needed. **2. How will you identify other residents having the potential to be affected by the same deficient practice and**	

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F 280	Continued From page 16 treatment of these burns. However, interview with the Director of Nursing confirmed that the temporary care plans do not become part of the permanent record. There was no evidence of preventative approaches added to the care plan to prevent future burns. f. Record review evidenced that the resident experienced an eye infection with Methicillin Resistant Staphylococcus Aureus (MRSA) in 3/10. There was a temporary care plan for the treatment of this infection, but MRSA was not listed on that plan or in the permanent care plan. The temporary care plan listed standard precautions instead of contact precautions for the resident's eye infection. The facility failed to update this resident's care plan when the resident's ADL status declined and failed to add new problems with approaches to the permanent care plan when the resident received burns and experienced an infection with MRSA. 2. Resident #9's medical record review revealed the resident was admitted to the facility on 7/3/02 with diagnoses which included: CVA (cerebrovascular accident), hypertension, hypothyroidism, depressive illness, DJD (degenerative joint disease) and hip pain. a. Review of the "Interdisciplinary Progress Notes" included the following: 8/12/09 "8 A (8:00 AM) Resident brought back from dinning room, she spilled her coffee in her lap. Groin area and left and right inguinal area red area rinsed with cool water and will continue to observe." The spill resulted in blisters to left and	F 280	**what corrective action (s) will be taken:** All residents that drink hot coffee or experience pain have the potential to be affected in this area. All residents were screened by the interdisciplinary team on 5-10-10 for the potential for hot liquid spills and care plans updated as needed. 3. **What measures will be put into place or what systemic changes will you make to ensure the deficient practice will not recur:** A mandatory all staff meeting held on 5-10-10to educate staff regarding hot beverage safety and pain management. 4. **Indicate how the center will monitor its performance to make sure the changes sustained. Indicate how the changes are integrated into and**	

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F 280	Continued From page 17 right inguinal areas. b. Review of the plan of care dated 8/5/09 and review 10/09 did not show the care plan was amended after the incident to address the resident's need for supervision in the dining room to prevent another incident with hot liquids. (Cross refer to F-323) 3. Review of the current plan of care for resident #8 and #6 revealed the care plans had not been updated to address the individualized resident needs for pain management. Both resident were identified during the survey as having pain management issues. (Cross refer to F309)	F 280	**evaluated by the quality assurance program:** An audit tool will be developed to audit residents safety with hot beverages and for pain. This audit will be completed 2 X per week for 4 weeks, then monthly for 3 months. The DDS and DNS, or their designees, are responsible for the completion of these audits. The results of the audits will be reported to the QA/CQI committee for further recommendations.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure staff provided care in accordance with professional standards of practice. This failure included the failure to provide appropriate care of a gastrostomy feeding tube, to provide resident instruction/cueing regarding an inhalation medication and to assess application of hot packs in accordance with professional standards of practice for one of thirteen sample residents (#1) and three supplemental sample residents (#15, #21 and #31) creating the potential for inappropriate, unsafe care. The findings included: 1. Observation of medications administered to	F 281	**5. Date when corrective action, (substantial compliance), will be completed** All corrective action will be completed by 5-16-10	

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F 281	Continued From page 18 supplemental resident #31 revealed the resident had a gastrostomy tube (G-Tube) and received all medications, fluids and nutritional preparations through this G-Tube. a. Prior to the administration of fluids and medications the nurse (T) did not evaluate the correct placement of the G-Tube by aspirating gastric fluid or auscultation of air/fluid in the upper portion of the stomach. 1) Professional standards in part state: Geriatric Care, Springhouse Co, 1997. Chapter 16, page 320: "Administering and Monitoring Medications. Auscultate the patient's abdomen about 3" (8 cm) below the sternum with the stethoscope. Then gently insert the 10 cc of air into the tube. You should hear the air bubble entering the stomach. If you hear this sound, gently draw back on the piston of the syringe. The appearance of gastric contents implies that the tube is patent and is in the stomach. If the medication was in tablet form, make sure the particles are small enough to pass through the eyes at the distal end of the tube. Reattach the syringe, without the piston, to the end of the tube and open the clamp. Deliver the medication slowly and steadily. Don't allow it to flow in too quickly; because of age-related changes in the GI tract, older patients are at risk for cramping. If the medication doesn't flow properly, don't force it." 2) Review of facility medication policies revealed a policy titled "Medication Administration Through Tube Feeding". This policy directed staff to check tube placement and patency. b. The nurse administered KCL (potassium chloride) and then Klonopin without flushing the	F 281	**F 281 Services provided meet professional standards.** **1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #31 was assessed for any potential problems related to g-tube medication administration. No problems were noted. Resident #15's skin was assessed for any harm caused by hot pack administration. No problems were noted. Resident #21 was assessed for any respiration problems caused by inhaler usage. No problems were found. Resident # 1 did not have any specific concerns identified. **2. How will you identify other residents having the potential to be**	

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F 281	Continued From page 19 tube between these medications. c. Review of facility medication policies revealed a policy titled "Medication Administration Through Tube Feeding". This policy directed "if more than one medication is to be administered, give each one separately and rinse tube with five cc (ml) of warm water in between medications." d. In an interview with the nurse after the observation she confirmed she had not checked tube placement before administering the fluid and medications. She also indicated the tube was to be flushed with water between each medication. 2. On 4/8/10 at 2:40 PM, in an interview with the restorative aide (RA) (N), she was asked if she applied hot packs to any residents and to describe how she applied hot packs. She indicated that resident #15 received hot pack treatments six times a week. The RA described how she did the hot pack treatment as follows: - Brought the resident to the therapy room. - Wrapped a hot pack from the Hydrocollator in three towels. - Placed the pack in the resident's neck for 10 to 15 minutes. The RA was asked if she looked at the resident's skin during the treatment to ensure that the skin was not getting too warm. She indicated that she did. When the surveyor asked if the nurse assessed the resident's skin during the treatment, the RA replied that the nurse did not do an assessment during the treatment. Asessment is not within the scope of practice for a restorative	F 281	**affected by the same deficient practice and what corrective action (s) will be taken:** No other residents receive medication via a g-tube. Residents who have inhale medication have been assess and problems addressed. Residents who receive hot pack treatment have had skin assessments completed and problems addressed. **3. What measures will be put into place or what systemic changes will you make to ensure the deficient practice will not recur:** A mandatory licensed staff inservice will be held on 5-10-10 to educate the nurses on the procedures for Tube feedings, hot packs, and inhalers. The Rehab/Medicare Nurse has changed the procedure for hot pack administration to include	

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F 281	Continued From page 20 aide. Standard: APPLICATION OF HEAT/COLD: Fundamentals of Nursing, The Art & Science of Nursing Care, Fourth Edition, Taylor, Lillis, LeMone, Lippincott, 2001, Chapter 37, pages 922-929: Skin Integrity and Wound Care: The nurse should assess the condition of the body area to be treated as well as the condition of the equipment to be used. An assessment of the resident should include response to stimuli, color and appearance of the body tissues involved, signs of altered circulation (pulses, blanching, temperature and color), level of consciousness and orientation of the resident. Ongoing assessments are made to ensure patient safety and comfort as well as to ensure appropriate response to the treatment. The nurse is responsible for checking the equipment used and for maintaining patient safety, including the distribution and constancy of the temperature. 3. On 4/6/10 at 6:10 PM, nurse (D) was observed to provide resident #21 with a Proair inhaler. The resident administered one puff of the medication and waited 30 seconds before administering the second puff. The nurse was present but did not cue the resident to wait longer between puffs of the medication. a. Review of the resident's physician orders evidenced that the resident was to receive two puffs of the Proair. b. On 4/9/10 at 8:35 AM, in an interview with the Director of Nursing, she verified that the resident had not been assessed to self administer medications.	F 281	skin assessments prior, during and after the heat pack treatment. The assessment will be completed by a licensed nurse. **4. Indicate how the center will monitor its performance to make sure the changes sustained. Indicate how the changes are integrated into and evaluated by the quality assurance program:** An audit tool will be developed to monitor G-tube feedings, application of hot pack with skin assessment in the middle and at the end of the procedure, and to monitor the administration of inhaler medications. The audit will be completed by the DNS or designee. The audit will be completed 2 x per week for 4 weeks, then monthly for three months.	

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F 281	Continued From page 21 c. Facility policy regarding "Medication" indicated the resident has the right to self-administer medications if the Interdisciplinary Team determines that this practice is safe for the individual resident. Policy on Inhalant Medications indicated if a second puff of the inhalant is to be given to wait one minute between puffs.	F 281	**5. Date when corrective action, (substantial compliance), will be completed** All corrective action will be completed by 5-16-10	
F 309 SS=G	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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and record review, it was determined the facility failed to provide necessary care and services for seven of thirteen sample residents (#1, #2, #6, #7, #8, #11 and #13) to attain or maintain the highest practicable physical, mental, and psychosocial well-being in regards to pain management (#2, #6, #7, #8 and #11), bowel care (#1), nutritional support and care after a burn (#2) and assessment/monitoring of resident #13 (closed record). These failures resulted in unrelieved pain for residents #6 and fecal impaction and subsequent hospitalization for resident #1. The findings included: BOWEL MANAGEMENT: Review of the medical record for sample resident #1 revealed the resident was admitted to the	F 309	**F 309 Failure to provide care and services that allow a resident to achieve and maintain their highest practical well being** **1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident # 1, # 2, #6, #7, #8, and #11will be assessed for pain. Any resident found to not have adequate pain management will have their primary care physician contacted and any new orders will be processed	

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F 309	Continued From page 22 facility on 6/14/08 with multiple diagnoses including COPD (Chronic Obstructive Pulmonary Disease), Congestive Heart Failure, hypertension, depression and a history of constipation. The resident was hospitalized in December 2009 for a "mechanical small bowel obstruction". a. In addition to these medical diagnoses which placed the resident at risk for constipation/fecal impaction he/she was also on several medications which contributed to this risk. These medications included antihypertensives, medications with anticholinergic effects, diuretics, and narcotic pain relievers. b. Review of BM (Bowel Movement) Records for the resident from 10/1/09 through March 2010 showed periods of time the resident went for several days without a recorded BM with no interventions recorded. From 10/2/09 to 10/08/09 (7 days) there was no recorded BM and no interventions noted on the MAR (Medication Administration Record). c. The resident's physician orders prior to the December 2009 hospitalization had an order for Metamucil daily, Milk of Magnesia (MOM) as needed (PRN), Bisacodyl suppository PRN and "may use Physician Protocols." d. The resident's physician orders referenced "Physician Protocols" which included the following interventions for constipation: 1) " Milk of magnesia 10ml (milliliters) conc. (concentrate) po (orally) prn (as needed) qd (every day) or 2) Fleets enema q (every) 3rd day rectally prn or 3) Bisacodyl supp (suppository) 10mg	F 309	including updating the care plan. Resident # 2, #6, #7, #8, and #11 will be assessed for bowel care and care plans will be updated. Resident #2 was reassessed by the registered dietitian on 4-26-10 and care plan was updated. Resident #13 is a closed record and no changes will be made to this document. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action (s) will be taken:** Residents who receive pain medication have had their medication regimen reviewed and updated as needed. The DNS/Designee reviewed the 24 hour reports since April 9th to make sure any residents needing follow up	

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F 309	Continued From page 23 (milligram) rectally prn. " e. The patient was hospitalized on 12/6/09 through 12/15/09. An abdominal/pelvic scan done 12/6/09 showed the patient had a "mechanical small bowel obstruction." Although the resident continued to be at high risk for constipation and fecal impaction the resident's hospital discharge medications did not include a stool softener. f. The patient was started on Morphine (narcotic pain medication) PRN on 12/18/09 after the resident was hospitalized and returned to the facility on 12/15/09. The resident was also on Ultram PRN, a pain medication which can cause constipation. g. From 12/26/09 to 12/29/09 (three days) there was no recorded BM and no MOM or suppository given. h. From 12/31/09 through 1/4/10 (4 days) there was no recorded BM. Although the resident was given MOM and suppositories on 1/4/10, 1/5/10 and 1/6/10 the resident did not have a BM until 1/9/10. i. The Hospital Emergency Room Report dated 1/9/10 indicated the resident had not had a bowel movement for two days, had complaints of nausea and abdominal distention. The resident had started on a Fentanyl patch for pain three days earlier (patch was started on 12/31/09). The resident indicated to the ER staff the pain had decreased but he/she had had no significant bowel movement since the patch had been started. j. The ER Plan indicated the patient was given	F 309	received appropriate follow up 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 registered dietitian will review the logs of all incident reports and will screened all residents with a history of hot liquid spills and completed nutrition re-assessments by 5-10-10 as needed. **3. What measures will be put into place or what systemic changes will you make to ensure the**	

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F 309	Continued From page 24 a Fleets enema with minimal results. The Fentanyl dosage was decreased and the physician indicated the resident "needs to be on Colace" twice a day. The "Impression" notation on this ER report indicated "Constipation secondary to pain medication." k. The resident was returned to the hospital emergency room on 1/9/10 for a "soap suds (SS) enema " l. In an interview with Unit Manager (M) on 4/6/10 at 2:20 PM she indicated the resident was sent to the ER for the SS enema because the facility did not have the equipment/supplies to provide this treatment. m. In an interview with the Director of Nursing on 4/8/10 at 1:30 PM she confirmed the facility did not have the ability to provide a SS enema when ordered for this resident. PAIN MANAGEMENT: 1. Record review revealed that sample resident #8 was admitted to the facility on 12/3/03 and readmitted from the hospital on 11/19/09. The resident's diagnoses included: hypertension, glaucoma, PMR (polymyalgia rheumatic), DJD (degenerative joint disease), chronic UTI (urinary tract infections), anxiety, depression, and pain. a. Review of the resident's "Progress Note" sheet from the physician dated 12/8/09 identified: "Past medical history remarkable for hospitalization November 17, 2009, because of abdominal pain and vomiting. The diagnosis was small bowel obstruction versus ileus. He/she had a history of fecal impaction, urinary tract infection,	F 309	**deficient practice will not recur:** All licensed Nurses and Medication Administration Assistance were educated on bowel care appropriate pain management, appropriate nutritional support for residents who have burns and following up on resident condition changes. Education included written testing. Nurse Managers/Designee will review the 24 hour report each working day to make sure appropriate follow up is being completed on their nursing unit. Condition changes will be reviewed and the follow done in response reviewed during the daily Nursing Department stand up meeting. **4. Indicate how the center will monitor its performance to make**	

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F 309	Continued From page 25 chronic renal insufficiency, dementia, Glaucoma, depression and anxiety." b. Review of the resident's Minimum Data Set (MDS) assessment dated 2/10/10 identified the resident's cognitive skill as moderately impaired, extensive assist of one person with ADL's, and pain was marked as zero. c. Review of the last pain assessment dated 2/16/10 identified the "resident denies pain". However the progress notes from 12/13/09 to 3/20/10 showed ongoing issues with nausea, abdominal pain, pain left ankle, and skin breakdown on right buttocks. There was no evidence that pain management was being addressed with these conditions. d. Observations and interview with resident #8 included: 1) 4/6/10 at 4:10 PM the resident was observed laying in bed. The resident reported having a back ache. 2) 4/7/10 at 8:35 AM resident #8 was observed seated in his/her wheelchair in the dining room. The resident was gripping the arm of the wheelchair with his/her left hand and was noted to have facial grimacing while leaning forward, attempting to reposition in the wheelchair. The resident was asked by the surveyor if he/she "needed help". The resident reported, "Yes, I hurt." At 8:48 AM the surveyor asked the nurse (G) to check on the resident as the resident continued to have facial grimacing and painful expressions. At 9:00 AM the nurse removed the resident from the dining room. Then the nurse asked the resident if he/she was having	F 309	**sure the changes sustained. Indicate how the changes are integrated into and evaluated by the quality assurance program:** **System Change:** The DNS has developed a PRN Pain sheet. All PRN pain medications will be documented on the PRN pain sheet. The PRN Pain sheet is the last sheet of the MAR. The new tracking system will help the staff identify the onset of new pain or if their pain management program is effective or not. The DDS will monitor residents with hot beverage burns or potential for hot beverage burns through dining observation to ensure that care plans for individual needs are carried out consistently.	

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F 309	Continued From page 26 pain, the resident responded, "Yes my back." The nurse asked the resident to rate his/her pain from 1-10. The resident stated, "It's a ten." The nurse then instructed the MA to give the resident a Tylenol. The resident was then left sitting in the hall. At 9:38 AM the DON was informed of the concern with the resident having pain which was rated by the resident as a ten. The DON then took the resident to his/her room and was laid down by CNA (B). The CNA used a sit to stand lift for the transfer. The resident reported, "Back hurts to sit". The CNA reported that the resident seem to be more comfortable laying down. 3) 4/8/10 at 5:10 PM resident #8 was observed seated in his/her wheelchair in the dining room. The resident was again noted to be gripping the arm of the wheelchair with his/her left hand and have facial grimacing. CNA (C) was asked by the surveyor to check the resident. The resident complained of having back pain. The nurse (E) was notified and Tylenol was given. e. Review of the MR (medication Record) dated 4/01/10 revealed the resident's medications included: -Ultram (Tramadol) was ordered 1/11/10 TID (three times a day) at 8:00 AM, 12:00 Noon and 8:00 PM. -Tylenol 650 mg po (orally) q 4 hours PRN (as needed) for pain/fever/sleep which was given on 4/7/10 and 4/8/10 after the surveyor reported the resident's complaints of pain. Additional, Tylenol had not been used in February or March 2010 There was no evidence the resident was	F 309	The DDS will conduct random audits of residents with hot beverage burns or potential for hot beverage burns weekly for three weeks and then monthly. The audits will be reported to the QA/CQI committee for 3 months and then as directed by the QA/CQI committee The DNS, or designee, will develop an audit to monitor bowel management, pain management, and assessment and observation of a resident. The audit will be completed weekly for four weeks and then monthly. The results of the audits will be reported to the QA/CQI committee for further recommendations.	

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F 309	Continued From page 27 reassessed for effective pain management with overall decline in the resident's condition and the resident's pain not being control with current medications. f. Review of the Care Plan sheet dated 12/09/09 identified: - Problem "Alteration in comfort R/T PMR, HA (headache) DJD, dizziness, GERD (gastroesophageal reflux) M/B HX. C/O leg pain, headaches." -Goal "Will have relief with pain med as ordered.", -Approaches included: "Med as ordered, assess pain using pain scale 0-10, Labs as ordered, Observe and report S/SX (signs and symptoms) of pain, Tx (treat) as ordered, use pain relieving techniques repositioning, massage the area, music, reading and activities". However there was no evidence the plan of care was updated to meet this resident's need for pain management with the resident's decline. g. Interview with nurse (M) 4/8/10 confirmed an overall decline in the resident's condition with generalized weakness, dysphasia and refusal to eat and pain. The nurse reported the pain assessment had been done while the resident was laying in bed and not up in the wheelchair. 2. Resident #6's medical record review revealed the resident was admitted to the facility on 6/30/99. The resident's diagnoses included: hypertension, diabetes, CHF (congestive heart failure), atherosclerosis, CVA (cerebrovascular accident), dementia, obesity and depression.	F 309	5. **Date when corrective action, (substantial compliance), will be completed:** All corrective action will be completed by 5-16-10	

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a. On 4/6/10 during the initial tour of the facility at 9:00 AM the resident was identified as being non ambulatory, transferred with a lift and being total care. Upon meeting the resident the resident had complaints of pain and about having increased pain in legs and hips when transferred into the wheelchair.

b. On 4/6/10 at 4:30 PM staff entered the resident's room to get the resident into the wheelchair. The resident complained about pain from hemorrhoids. Staff continued with care without responding to the resident complaints of pain. Staff was asked to check with the nurse before continuing to get the resident up. The nurse checked the resident and applied medication to the area. After the nurse left the room the resident stated, "Thank you. They just don't listen when I try to tell them things."

c. Review of the monthly MR (medication Records) for 4/10, 3/10, 2/10 and 1/10 revealed the following:

Ecotrin (Aspirin) 325 mg po (orally) q d (everyday),

Darvocet N-100 1 tab TID (three times a day) started 7/31/09 for pain.

The Darvocet N-100 was stopped on 2/23/10 and changed to Tylenol Arthritis Strength one tab po QID (four times per day).

Risperdal 0.25 mg po BID (twice a day) started 1/20/10 and increased to 0.5 mg BID on 2/17/10,

Ativan 0.5 mg TID PRN (as needed) for anxiety,

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F 309	Continued From page 29 -24 PRN doses given in January 2010 for calling out, hollering and anxiety, -6 PRN doses given in February 2010 for calling out, hollering and anxiety, d. Review of the last pain assessment dated 3/24/10 identified the resident complained the "lift hurts legs" and hemorrhoidal discomfort. The nurse note stated, "Scheduled Tylenol, recently DC'd scheduled Darvocet can also have hemorrhoidal cream and Tylenol PRN as ordered. Usually effective but also note behaviors vs discomfort are hard to separate." There was no evidence that pain management was assessed prior to starting the resident on Risperdal 0.25 mg po BID (twice a day) on 1/20/10 and increasing it to 0.5 mg BID on 2/17/10. There was no evidence that pain medication and alternate interventions were attempted prior to transfers in attempt to reduce the resident's pain in those situations and provide for an optimum level of pain management. e. Review of the Care Plan sheet dated 1/05/10 identified: - Problem "Alteration in comfort R/T severe DJD, occasional H/A (headaches), cough and upset stomach." -Goal "Will have no c/o of pain on scheduled pain med.", -Approaches included: "Med as ordered, assess pain using pain scale 0-10, reposition for comfort Q2HR and PRN and message/rub affected area."	F 309		

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F 309	Continued From page 30 However there was no evidence the plan of care was updated to meet this resident's need for pain management with complaints of pain in hip and legs with the lift, increase in anxiety and hemorrhoidal discomfort. 3. Review of the 1/10, 2/10, 3/10, and 4/10 Medication Administration Records (MARs) for residents #2, #11, and #7 revealed that these residents were medicated for pain. The residents' level of pain before and after these medications was not consistently assessed using the facility's pain assessment scale(s). 4. Review of the facility policy titled "Pain Management-Resident Assistance" revealed the following: "Purpose: To provide residents assistance in pain management. Policy All residents will receive interdisciplinary consultations on assistance in managing pain. When a resident is identified as being in pain, the social worker, as part of the Interdisciplinary Team, will assess the psychosocial well-being of the resident. Individualized approaches will be developed to address the resident's pain management needs in a holistic manner. The registered nurse will assess current pain levels and develop with the physician and interdisciplinary team, interventions which may be non-pharmacological as well as pharmacological. The registered nurse will review response to medication intervention and work closely with the physician to assist in the individualized pain	F 309		

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F 309	Continued From page 31 measurement plan." 5. Review of the facility procedure titled "Pain Data Collection and Management" revealed the following: "Purpose: To consistently collect information for data collection of pain in a systematic process To determine what pain relief interventions can be utilized and established to aid resident in maintaining comfortable level of function in ADLs, eating, mobility and all other physical activities Note: A pain management plan can include, but not be limited to, a medical regime. The analysis should help determine what other methods or alternatives of pain control/relief may be implemented prior to contacting a physician. The Care Team and nurses must continually monitor and evaluate the pain management plan." ASSESSMENT AND MONITORING: 1. Resident #13's closed record review revealed the resident had been admitted to the facility on 8/15/07. The admission diagnoses included: coronary artery disease, cataracts, glaucoma, dementia, anxiety and history of myocardial infarct. a. The review showed that from 7/12/09 to 7/14/09 the nursing staff documented the resident had signs and symptoms of a cold which included a hoarse cough, elevated temperature and generalized discomfort. The "Interdisciplinary Progress Notes" included:	F 309		

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F 309	Continued From page 32 7/12/09 10:30 PM, "Congested sounding temp 98, Tylenol 650 mg, PO (oral) given for comfort and sleep." 7/13/09 10:00 AM, "Res. has clear nasal drainage, lungs clear bil. (bilateral) t. (temperature) 96.7, P-(pulse) 72, R-(respiration) 16, B/P (blood pressure) 92/56- daughter here aware of mothers 'Cold Symptoms'." 7/13/09 8:30 PM, "Res con't to have cold symptoms. T.97.1 c/o (complained of) general body aches and discomfort. Tylenol 650 mg given PO with HS (bedtime) meds." 7/14/09 3:30 PM, "96.5-63-18 102/65 (B/P), Resident cont. with cols S/S (signs and symptoms), horse, non productive cough noted, lungs clear will cont to monitor." Although the staff identified a need to monitor the resident there was no documentation from 7/14/09 to 7/20/09, the resident's was provided care and monitoring for his/her "cold symptoms". The next entry on 7/20/09 (6 days later) showed a decline the the resident's condition. The entry stated, "Continues with cold sx T-97.7, P-108, R-22, O2 89% (oxygen saturation), Rhonchi to upper L (left) Lobe. Daughter (_name) here with concern. Appt. (appointment) made at AUR (?) for 3:00 today." At 2:45 PM the resident left the facility. At 3:30 PM the note stated, "Resident admitted to (__name) hospital with possible pneumonia."	F 309		

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F 309	Continued From page 33 b. Review of the "Discharge Summary" from the hospital identified the resident as being admitted to the hospital on 7/20/09 with diagnosis which included: ARDS (Adult respiratory distress syndrome), bilateral pneumonia, coronary artery disease and dementia. NUTRITIONAL CARE AND SERVICES AFTER A BURN: Review of resident #2's medical record evidenced the resident had sustained second degree burns on his/her abdomen and thigh on 2/3/10. The burns were documented to be from hot coffee. On the resident's temporary care plan for these burns, there was a note the Dietitian was notified of the burn. On 4/7/10 at 3:26 PM, in an interview with the consultant Registered Dietitian (RD), resident #2's burn from spilled coffee on 2/3/10 was discussed. The RD verified she wrote nutritional progress notes for this resident on 2/1/10 and 3/1/10, but that she had not been notified of the resident's burn. She revealed that the burn was healing and the resident's previous albumin (12/09) level was acceptable at 3.8. The surveyor's meal observations of the resident receiving limited meal assistance and his/her meal intake (approximately 10%) at the 4/6/10 evening meal and 4/7/10 noon meal were discussed with the RD. The RD reviewed the resident's weight and indicated a slow weight loss was occurring. The RD commented that the resident would be added to her nutritionally at risk list.	F 309		

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GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

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F 309	Continued From page 34 The staff failed to fully implement the plan of care developed in relation to the resident's burn. Reference: 2005 American Dietetic Association, Scope of Dietetics Practice Framework, Standards of Practice in Nutrition Care for the Registered Dietitian (RD) " STANDARD 2: NUTRITION DIAGNOSIS The registered dietitian identifies and describes an actual occurrence, risk of, or potential for developing a nutrition problem that the registered dietitian is responsible for treating independently. Rationale: At the end of the assessment step, data are clustered, analyzed and synthesized. This will reveal a nutrition diagnostic category from which to formulate a specific nutrition diagnostic statement. A nutrition diagnosis changes as the client response changes, whereas a medical diagnosis does not change as long as the disease or condition exists. There is a firm distinction between a nutrition diagnosis and a medical diagnosis. The main difference between the two types of diagnoses is that the nutrition diagnosis does not make a final conclusion about the identity and cause of the underlying disease. A client may have the medical diagnosis of "Type 2 diabetes mellitus"; however, after performing a nutrition assessment, the RD may determine a nutrition diagnosis(es) with nutrition diagnostic labels for example, "excessive energy intake" or "excessive carbohydrate intake". In the community or public health setting the nutrition diagnosis may relate to a population based condition (food safety and access) rather than a medical diagnosis. Examples of nutrition diagnostic labels may then be "intake of unsafe	F 309		