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 _____	04/09/2010

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 35 food" or "limited access to food". The nutrition diagnosis(es) demonstrates a link to setting realistic and measurable expected outcomes, selecting appropriate interventions and tracking progress in attaining those expected outcomes." " STANDARD 3: NUTRITION INTERVENTION The registered dietitian identifies and implements appropriate, purposefully planned actions designed with the intent of changing a nutrition-related behavior, risk factor, environmental condition, or aspect of health status for an individual, target group, or the community at large. Rationale: Nutrition intervention involves a) selecting, b) planning and c) implementing appropriate actions to meet clients' nutritional needs. The selection of nutrition interventions is driven by the nutrition diagnosis and provides the basis upon which outcomes are measured and evaluated. An intervention is a specific set of activities and associated materials used to address the problem. The registered dietitian may actually perform the interventions, or may delegate or coordinate the nutrition care that others provide. All interventions must be based on scientific principles and rationale and when available grounded in a high level of quality research (evidence-based interventions). The registered dietitian works collaboratively with the client, family, caregiver or community to create a realistic plan that has a good probability of positively influencing the nutrition diagnosis/problem. This client driven process is a key element in the success of this step, distinguishing it from previous steps that may or may not have involved the client to this degree of participation."	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 _____	04/09/2010

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 36 According to the CD-HCF (Consultant Dietitians in Health Care Facilities) Pocket Resource for Nutrition Assessment 2001 Revision, page 2, a "Nutrition assessment is a comprehensive approach completed by the dietetic professional to define nutrition status which employs medical history, nutrition intake, nutrition history, medication, physical examination, anthropometric measurements and laboratory data. Nutrition assessment includes interpretation of data from the screening process. The assessment process includes a review of other disciplines' data that may affect the assessment process such a physical therapy, occupational therapy, speech therapy, etc. It includes the organization and evaluation of information to declare a professional judgment. Nutrition assessment precedes a care plan, intervention and evaluation."	F 309	**F 311 Treatment/services to improve or maintain ADL's.** **1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents #2, #7, #9, #11, #15, #16, #17, #23, #24, #26, #27 and #28 had their nutritional status reviewed by the Registered Dietician and were assessed for weight loss. Their care plans were updated as needed. **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:** Nurse Manager/Designee and the Registered Dietician reviewed the nutritional status of all residents. The residents	
F 311 SS=E	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure appropriate positioning, set up, and prompting of residents during meal times for four of thirteen sample residents (#2, #7, #9 and #11) and eight supplemental sample residents (#15, #16, #17, #23, #24, #26, #27 and #28) creating the potential for poor meal intake and weight loss. The findings included: 1. On 4/6/10 from 4:55 PM to 6:08 PM, the	F 311		

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 _____	04/09/2010

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 311	Continued From page 37 following observations were made during the evening meal: a. Certified Nurse Aide (CNA) (F) was seated between residents #25 and #26. The CNA was observed to assist resident #25. Resident #26, who was served his/her food at 5:25 PM, received very limited assistance and was not cued to eat. The resident had consumed approximately 10% of his/her food before being taken out of the dining room at 5:45 PM. b. Resident #2, who was seated at the same table as residents #25, #26, and #27, was served his/her food at 5:25 PM. The resident attempted to feed him/herself. The resident's coffee cup with a spoon in it was placed near the edge of the table. The resident was not offered any assistance or cueing until 5:37 PM at which time the CNA (F) assisted the resident. The resident consumed about 10% of the food of his/her food. c. Resident #28 was served his/her food at 5:15 PM. He/she drank his/her milk and coffee and ate a few bites of food. No staff assisted, cued, or offered the resident alternates. The resident left the dining room at 5:28 PM. d. Resident #23 was observed to spill his/her food from the fork to his/her lap and onto the floor. The resident also pushed food off the edge of the plate while trying to load the fork. The resident's food was served on a regular plate (no edge, plate guard, or divided plate). No staff assistance was provided to the resident. 2. On 4/7/10 at 8:40 AM, resident #7 was observed in the dining room. He/she was leaning to the right side in his/her wheelchair. When the	F 311	were also assessed for weight loss. Their care plans were 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:** Nursing and Dietary staff were educated on 5-10-10 on providing assistance at meals. This included the used of adaptive eating utensils, safety with hot beverages, using cues to encourage residents, positioning residents at meals and ensuring that residents receive adequate meal intake. **4. Indicate how the center will monitor its performance to make sure the changes sustained. Indicate how the changes are integrated into and**	

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 _____	04/09/2010

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 311	Continued From page 38 resident's food was served at 8:47 AM, CNA (O) assisted the resident to eat but did not re-position the resident. 3. On 4/7/10 from 11:43 AM to 12:42 PM, the following observations were made during the noon meal: a. Residents #2, #25, #26, and #27 were seated at a table. From 12:06 PM to 12:22 PM, CNA (N) assisted resident #25 and did not encourage or assist the other residents seated at this table. At 12:22 PM, resident #25 and the CNA left the table. b. Resident #26 who was served his/her food at 11:47 AM was not offered assistance until 12:37 PM. The Director of Nursing (DON) briefly checked with the resident to see how he/she was doing. Then the DON walked away from the table. The resident ate slowly. c. Resident #2's wheelchair was positioned approximately eight inches from the table and the resident was leaning backwards in his/her wheelchair. The resident was served his/her meal at 11:47 AM and did not receive staff assistance or encouragement and was not repositioned. When the resident reached for food on the table, his/her arm was extended straight out. At 12:08 PM, CNA (B) sat down at the table next to the resident, as she (the CNA) recorded meal intakes. At this time residents #2, #27 and #26 were still eating. At 12:39 PM, when the DON spoke to resident #2, the resident was finished eating and had consumed approximately 10% of the meal. d. Residents #11, #3, and #24 were seated at	F 311	**evaluated by the quality assurance program:** An audit tool will be developed to monitor the use of adaptive equipment, adequate staff assistance at meals, proper positioning of residents to avoid weight loss or aspiration of food or fluids. The Dietary Manager will complete 5 audits per week. The audits will cover all 3 meals. 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:** All corrective action will be completed by 5-16-10	

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 _____	04/09/2010

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 311	Continued From page 39 one table. Residents #3 and #11 were sleeping at the table. Neither resident #11 or #24 were assisted with or encouraged to eat their meals and consumed approximately 10% and 50%, respectively. 3. Observations during the evening meal on 4/6/10 included: a. There were four residents seated at table 16. One resident was being assisted by a family member. The other three resident's (#15, #16 and #17) were served by 5:30 PM but were not offered timely cueing and assistance. Resident #16 was noted to get up several times to go to another table but was cued by the other resident's family to come back to the table. However the resident left the table and the dining room at 5:45 PM without being cued by staff to eat. Resident #15 was seated in a wheelchair with the back of the wheelchair extended back in a semi reclined position. The resident was noted to take drinks from the cups with a straw and trying to feed himself/herself. However due to the reclining position the resident was noted to spill food down her front and on to the clothing protector. The resident was then observed to use a spoon in an attempt to eat the spilled food off his/her clothing protector. The resident was not offered assistance with positioning until 5:53 PM. This was 23 minutes after her food was served. Resident #17 was cued by the other resident's family to eat however was not cued and assisted by staff until 6:00 PM (30 minutes after food was served).	F 311		

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 _____	04/09/2010

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 311	Continued From page 40 b. There were four residents which included resident #9 and #19 seated at table 15. Resident #9 was served at 5:25 PM. The resident was seated in a wheelchair with a half tray on the right side of the wheelchair. The tray prevented the resident from getting close to the table. The resident was noted to lean forward and reach with the left hand in an attempt to eat. The resident was observed to spill food on the table and floor. The CNA assisting resident #19 made no attempt to assist resident #9. 4. Observations during the noon meal on 4/7/10 included: Resident #9 was served at 12:10 PM. The resident was noted to sleep at the table. The resident was not cued until 12:30 PM to eat by nurse (G). Staff did not assist the resident until 20 minutes later. There was a CNA (H) who was seated at this table assisting resident #19 but the CNA made no attempt to cue or assist resident #9.	F 311	**F 312 ADL care provided for dependent residents.** **1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #3 , #12, and #29 will have their individual needs met by providing timely and adequate assistance at meals. Resident #29 will also have ST review the swallowing instructions needed for this resident and the care plan will be updated based on the outcome of this assessment. **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:**	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure timely meal assistance for two of thirteen residents (#3 and #12) and one supplemental	F 312		

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 _____	04/09/2010

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 312	Continued From page 41 residents (#29) who required total/extensive meal assistance creating the potential for poor meal intake and weight loss. The findings included: 1. Observation of the dining room on 4/7/10 during the evening meal revealed two residents were not served a meal in a timely manner after others at the table had been served (Resident #3 and supplemental sample resident #29). 2. At 12:20 PM, in an interview with dietary staff (J), she stated that two residents had not yet been served as they were waiting for staff to be available to assist these residents. 3. 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. Observation of the resident during meal times on the days of the survey revealed the resident was a total assist of meals. The resident was observed to cough and choke during the staff's assistance with the meals. Staff did not consistently instruct the resident to chew and to keep his/her chin down as per speech instructions. 4. On 4/7/10 from 11:43 AM to 12:42 PM, the following observations were made during the noon meal: a. Residents #11, #3, and #24 were seated at one table. Residents #11 and #24 received their meals at 12:00 noon.	F 312	Nurse Manager/Designee and the Registered Dietician reviewed the nutritional status of all residents. The residents were also assessed for weight loss. Their care plans were 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:** All Nursing Staff were educated on 5-10-10 on providing appropriate and timely assistance to residents. The training was conducted by the Dietary Manager and included written testing. Dietary Staff were educated on the need to serve meals in a timely manner. Education included written testing. A licensed nurse has been assigned to supervise meal service each meal.	

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 _____	04/09/2010

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 312	Continued From page 42 b. Resident #3 was observed to be sleeping at the table at 11:47 AM. At 12:16 PM, the resident had not been served his/her meal. c. At 12:25 PM, the resident's food was served by CNA (L). The resident complained about hurting and only drank warm water and took a few small bites of food. The resident was removed from the dining room at 12:45 PM and taken to the nurses' station for the resident to be medicated for pain. This CNA was not aware of how long the resident had been up in the wheelchair since she took over another CNA's assignment at 10:00 AM.	F 312	The supervisor duties include checking for timely assistance to residents. Any problems noted will be followed up immediately. 4. An audit will be developed to monitor meal serving times on all three meals, ensure residents do not choke or experience coughing during meals, and that all residents at the same table will be served at the same time. The Dietary Manager/Designee will complete the audits. 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:** All corrective action will be completed by 5-16-10	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents received adequate supervision and assistance devices to prevent burns from hot liquids for three of thirteen sample residents (#10, #9 and #2). The facility failed to provide a system of prevention of burns after an initial burn occurred to resident #9. Subsequent burns occurred to resident #2 (2nd degree burns) and resident #10. The findings included:	F 323		

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 _____	04/09/2010

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 323	Continued From page 43 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 11/28/09 admit Minimum Data Set (MDS) evidenced that the resident was assessed to require extensive or total assistance by one or two staff members for bed mobility, transfer, locomotion, dressing, personal hygiene, and bathing and supervision with eating. b. Review of the 2/18/10 physician progress note revealed that "_____ (He/she) recently had some 2nd degree burn from hot coffee on ___(his/her) thigh and lower abdomen and this is being treated with Silvadene cream and this is slowly healing..." c. Review of the resident's Interdisciplinary Progress Notes documented the following: 1) 2/3/10 8:30 AM "Resident drowsy this AM & needed to be fed & enc (encouraged) to drink fluids. Kept falling asleep. Then became alert to ask for coffee. ____(?) added sm (small) amt (amount) cool water & warned re: being hot. Took a sip & either cup was to heavy or missed talbe & coffee spilt (sp?) on lower R (right) abd (abdomen) & R upper leg/thigh Reddness below & above pull up. All fluid sopped up with napkin & poured cold water on it immediately & then cold H20 (water) with ice to areas x 20 min." 2) 2/3/10 9:00 AM "Layed down & cool clothes reapplied. Reddness continues with blister x 1 noted . Areas measure: 8 x 4 cm (centimeter) to	F 323	**F 323 Prevention of Accidents** 1. **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents # 10, #9 and #2 will have their individual needs met by ensuring their skin is intact and free from burns. The ID team screened each resident for the safety with hot beverages, use of an assistive devices with hot liquids, and care plans updated on 4-30-10. **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 were screened by the interdisciplinary team on 4-30-10 for the potential for hot liquid spills	

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 _____	04/09/2010

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 323	Continued From page 44 upper R leg and lower R abdomen 12 x 7 cm. Dr faxed by _____(LPN) & questioned re something for burn is silvadene...." 3) 2/3/10 12:00 PM "Daughter _____(name) re: ....coffee burns this AM @ table." 4) 2/3/10 1:12 PM "MD order for silvadene..." 5) 2/6/10 12 N "Burn areas obs (observed) - area has blister areas with sm amt yellow drng (drainage) to abd area - (sign for no) drng to L (left) upper thigh..." 6) 2/10/10 9 P "Dressing change done to thigh and abd. All blisters broken open. Silvadene cream resumed. (sign for no) redness noted. ..." 7) 3/01/2010 3 P ""/referral (verbal) to Dietician re: _____(name) 2nd to burns, to review intakes and wts (weights) with diet and advise." 8) 3/16/10 9:30 PM "Burn on abdomen looks worse compared to a week ago when I last saw it. Area and (arrow up for increased) grey drainage and bleeding some. Last week only small amt of grey drainage and tint of blood." 9) 3/17/10 7 PM ".... yellow matter in eye.... ___(sign for change) dressing yellow & brown drg. (from burn area)..." 10) 3/22/10 3 PM "Clinic called culture + (positive) for MRSA of eye...." d. Review of the resident's Wound Flow Sheets revealed the following: Upper thigh	F 323	and care plans updated as needed. Assistive devices have been purchased for use by residents with hot beverage burns or potential for hot beverage burns as directed by individualized care plans. **3. What measures will be put into place or what systemic changes will you make to ensure the deficient practice will not recur:** Upon admission, residents are reviewed for potential for hot beverage spills through observation and assessment, with assistive devices put into place as needed. Care plan to reflect the needed assistance or adaptive equipment needed for at risk residents. A licensed Nurse has been assigned to supervise the meal service for each meal.	

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 _____	04/09/2010

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 323	Continued From page 45 1) 2/3/10 - 8 x 4 cm, no drainage 2) 2/12/10 - 6.4 x 4 cm, no drainage 3) 2/18/10 - 4 x 0.8 cm, no drainage 4) 3/5/10 - 3 x 2 cm, no drainage 5) 3/25/10 - healed. Lower abdomen 1) 2/3/10 - 12 x 7, no drainage 2) 2/12/10 - 5 x 3 (white spot), moderate drainage 3) 3/5/10 - 2.8 x 1.5 cm, moderate drainage 4) 3/13/10 - 2.5 x 1.5 cm and 2.5 x 2 cm, moderate drainage 5) 3/19/10 - 4 x 2 cm, moderate drainage 6) 3/25/10 - .4 x 2 cm and .2 x 2 cm, minimum drainage 7) 4/6/10 - 3 pinpoint scabs, no drainage. e. On 4/8/10 at 4:00 PM, in an interview with the Infection Control Coordinator, she verified that the resident had MRSA in his/her eyes and that the wound drainage had not been cultured. f. There was a temporary care plan for treatment of the resident's burns. However, interview with the Director of Nursing confirmed that the temporary care plans do not become part of the permanent record. Review of the resident's care	F 323	On an ongoing basis, the interdisciplinary team will address hot beverage safety concerns with all care plan reviews. This information will be made available to Nursing staff via the handheld computer devices. All staff were in-serviced on 5-10-10 regarding hot beverage safety, use of adaptive equipment, and the communication to the nursing staff and dietary staff all hot liquid spills. **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:** The DDS will monitor residents through observation to ensure that supervision and assistive devices are being consistently provided to	

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 _____	04/09/2010

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 323	Continued From page 46 plan failed to show evidence of preventative approaches being added to the care plan to prevent future burns. There was an approach added to assist the resident at meals. g. Observations during the survey revealed that the resident was provided very limited assistance with eating and supervision to prevent another coffee spill (Refer to F311). h. 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 suggested the use of covered coffee cups for residents who needed meal assistance in order to decrease possible spills of coffee which might cause burns. 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 annual MDS (minimum data set) assessment dated 7/24/09 identified the resident with cognitive skills moderately impaired, needing extensive assistance with ADL's (activities of daily living), partial loss and limitation in ROM (range of motion) and supervision and set up help with eating. b. 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	F 323	each individual resident per care plan. The DDS will conduct a random audit by observing residents in the dining room to ensure that needs have been addressed and report to the interdisciplinary team. The audits will also 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:** All corrective action will be completed by 5-16-10	

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 _____	04/09/2010

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 323	Continued From page 47 observe." The next entry was approximately six hours later. "2:15 P (2:15 PM) Resident groin area red left and right inguinal areas have blisters. Right 4.2 cm x 3 cm blister. Left .2 cm x 1 cm blister." There was no documentation the resident was assessed for pain with the burn. "2:35 P (2:35 PM) (____name of family) called and notified of coffee being spilled and and reddened blistered area, explained we would give her warm coffee from now on. Verbalized understanding." "2:45 P (2:45 PM) Telephone call made to (___physician name) office message left by (__nurse)." "3 PM (3:00 PM) T.O. (telephone order) received and observed per (__physician name)." The next entry was 3/18/09 which addressed a lab draw. c. Review of the T.O. dated 8/12/09 stated, "Silvadene topical TID (three times a day) x 1 week to affected area. DX (diagnosis) burn." d. Review of the plan of care dated 8/5/09 and review 10/09 did not show the care plan was revised after the incident to address the resident's need for supervision in the dining room and not to be served "hot liquids" due to incident with coffee spill which resulted in burns. 3. Review of the medical record for sample resident #10 revealed the resident was admitted to the facility on 2/21/05 with diagnoses of seizure	F 323		

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 _____	04/09/2010

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 323	Continued From page 48 disorder, depression, cerebral ischemic stroke with right hemiparesis, dementia, cataracts and arthritis. The resident's medication regime included antidepressants. a. The facility had identified self care deficits but there was no assessment of the safety of this resident in the handling of hot liquids after other residents in the facility had received burns from coffee spills (Sample resident #9 had a burn from hot coffee on 8/12/09 and resident #2 had a 2nd degree burn on 2/3/10). b. The medical record indicated the resident spilled coffee on himself/herself on 3/31/10 while eating in his/her room. The resident experienced reddened areas to his/her upper and inner thighs which required application of ice packs. 4. On 4/7/10 at 8:50 AM, observation evidenced that staff obtained coffee for residents from the coffee maker located on the counter in the dining room. The temperature of the coffee (using the surveyor's digital thermometer) was 159.4 degrees Fahrenheit (F). When dietary staff member (I) was asked to provide a facility thermometer to re-check the coffee temperature, she stated that the thermometers were downstairs in the kitchen. She called dietary staff member (J) to bring a thermometer to the dining room. Using the facility's dial thermometer, a newly filled cup of coffee was tested. The coffee was steaming but the temperature was 130 degrees F; the surveyor's thermometer indicated that the temperature was 164.4 degrees F. Dietary staff member (J) used her own dial thermometer and obtained a reading of 164 degrees F.	F 323		

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 _____	04/09/2010

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 323	Continued From page 49 5. On 4/7/10 at 6:10 PM, in an interview with the Administrator and the Director of Nursing (DON), the coffee temperature was discussed. The Administrator revealed that the temperature of the coffee in the machine could not be not be turned down.	F 323	**F 329 Unncessary Drugs.** **1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #12 has had his/her physician informed of the abnormal movements. The medication was reduced. Residents #4, #5, #11 and #12 have had their drug regimen reviewed and recommendation have been implemented according to the direction of the resident's physician. **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 on antipsychotic mediation	
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and record review, it was determined	F 329		

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 _____	04/09/2010

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 329	Continued From page 50 the facility failed to ensure resident medication regimens were free of unnecessary drugs, failed to ensure adequate monitoring of medication effectiveness and failed to ensure appropriate Gradual Dose Reduction of antipsychotic drugs for four of thirteen sample residents (#4, #5, #11 and #12). This failure resulted in resident #12's development of drug side effects including abnormal trunk and oral movements. The findings included: 1. 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. Review of the resident's Medication Administration Record (MAR) and physician orders indicated he/she was currently on Risperdal 0.5 mg orally every morning and 1 mg every evening for "Impulse Control Disorder". Risperdal is an antipsychotic medication used to treat the symptoms of schizophrenia, irritability associated with autistic disorder and the manic symptoms of bipolar disorder. b. The resident had been on this current dose of Risperdal since 2/09. A Gradual Dose Reduction was done in 2/09 with good results, i.e. no return or increase of intolerable behaviors. c. A Psychiatric Progress Note dated 2/18/09 indicated the resident's behaviors "has been good", but did not indicate what behaviors the staff should monitor in regards to the Risperdal. The note indicated "No suicidal/homicidal ideation or overt psychosis noted" and the Risperdal was	F 329	have had their drug regimen reviewed and recommendations have been implemented according to the direction of the resident's physician. **3. What measures will be put into place or what systemic changes will you make to ensure the deficient practice will not recur:** All Licensed Nursing staff have been educated 5-10-10 on the GDR procedure. Education included a written test. The facility has formed a Reduction Committee that will be responsible to monitor and implement any GDR. The Reduction Committee will track all antipsychotic medications used by all residents and present a plan for GDR to the resident's physician. The DNS/Designee and Social Service will be responsible to make sure the Reduction Committee	

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 _____	04/09/2010

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 329	Continued From page 51 reduced to 0.5 mg in the morning and 1 mg in the evening. d. Subsequent Psychiatric Progress notes (6/17/09, 8/19/09, 10/21/09, 12/16/09 and 2/17/10) showed an absence of problematic or intolerable behaviors. The resident remained on the same dose of Risperdal with no further attempts to reduce the dose regardless of the absence of problematic behaviors. e. An interview on 4/7/10 at approximately 1:00 PM with the Unit Manager (M) revealed the resident's Impulse Control Disorder would be exhibited by resisting cares and anger at the staff. This staff member was asked for the behavior monitoring to show any episodes of these behaviors. f. Review of the "Mood & Behavior Record" for the time period of 2/1/09 through 4/8/10 showed no episodes of inappropriate behavior. The form did not list the behaviors to be monitored. g. The most current Minimum Data Set assessments (quarterly dated 2/12/10 and quarterly dated 11/13/09) did not show indications of delirium or behavior symptoms. h. The pharmacy Medication Regimen Reviews from February 2009 through April 2010 for resident #12 did not show any recommendation for a GDR of the Risperdal. i. Behavior documentation notes from 2/12/09 through 2/11/10 indicated the resident was on the Risperdal for "Impulse Control Disorder" and "no documented behaviors".	F 329	procedure is followed. The facility will also track all resident behavior through the Behavior Committee. Social Service will be responsible to make sure the procedure is followed All Staff have been educated on the Behavior Committee and the importance of tracking resident behavior. Education included written testing. **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 the date a dosage reduction was last attempted and the date of the AIMS assessment. The audit will be completed by the DNS or designee.	

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 _____	04/09/2010

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 329	Continued From page 52 1) There was no Behavior documentation of what behaviors were being monitored or how the resident's "impulse control disorder" was exhibited. 2) There were no Behavior documentation notes regarding the side effects of this medication or the Abnormal Involuntary Movement Scale (AIMS) assessment conducted in early March which showed the development of abnormal movements. j. An evaluation of AIMS assessment was conducted on 8/24/09. This evaluation showed no changes or presence of abnormal facial and oral, extremity, or trunk movements. k. An AIMS assessment completed on 3/4/10 indicated the resident was exhibiting abnormal upper extremity and trunk movements. The form indicated the attending physician was notified and the medical record showed the physician had ordered Cogentin 0.5 mg twice a day for "extrapyamidal side effects". The order indicated to have the psychiatrist review the medications. Although the psychiatrist was ordering and monitoring the resident's psychoactive medication (Risperdal), there was no evidence the psychiatrist had been consulted regarding these new side effects and did not review these changes until 3/17/10. l. The psychiatric progress note dated 3/17/10 indicated the resident was demonstrating some abnormal mouth movements. The progress note did not indicate the 3/4/10 AIMS assessment showed abnormal trunk and extremity movements. The note indicated "mouth and tongue movements which were in a serpentine	F 329	The audit will be completed 2 X per week for four weeks, then monthly for three months. The results of the audits will be reported to the QA/CQI committee for further recommendations. **5. Date when corrective action, (substantial compliance), will be completed:** All corrective action will be completed by 5-16-10	

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 _____	04/09/2010

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 329	Continued From page 53 pattern"..."buccal oral movements consistent with Tardive Dyskinesia." The note also indicated "behavior has remained tolerable". Assessment data indicated resident "does have Tardive Dyskinesia but I do not want to reduce the Risperdal at this time given that I have reduced it in the past and we have had trouble with (his/her) behaviors." m. Although there was no evidence the resident experienced a worsening of his/her condition after the 2/09 GDR, no further attempts of a GDR were evident. n. Although the psychiatric progress note dated 3/17/10 indicated abnormal mouth movements this was not evident on the AIMS dated 3/4/10. o. In an interview with the psychiatrist on 4/9/10 at approximately 8:30 AM he indicated he based decisions to change a resident's medication regimen (i.e. initiate therapy or attempt GDR) on behavior tracking communicated to him by the facility/nursing staff. The psychiatrist indicated if a resident was not having behaviors, if the behaviors were tolerable or significant side effects developed, a GDR should be considered. p. He indicated he was not made aware resident #12 was having increased coughing and choking at meals. He confirmed better communication of the resident's current (i.e. up-to-date) behaviors were not consistently given to him. q. On 4/2/10 an interdisciplinary progress (IDP) note indicated several staff had expressed a concern regarding the resident's coughing spells when eating.	F 329		

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 _____	04/09/2010

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 329	Continued From page 54 r. Observation of the resident during meal times on the days of the survey revealed the resident required total staff assistance with meals. The resident was observed to cough and choke during the staff's assistance. s. A Dysphagia Evaluation was completed by the Speech Therapist on 4/7/10. This evaluation indicated the resident had been coughing during meals and was a full assist with meals, "reminders to chew and keep chin down". She indicated fatigue was also an issue for resident having increased risk of aspiration. The resident's current plan of care did not include the current assistance reminders for the staff. t. Successful GDR, with no adverse effects/behaviors, occurred in 2/09. No attempts to further reduce the Risperdal was evident from 2/09 to 3/10 or after 3/10 with the development of medication side effects. 2. 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. Review of the resident's care plan indicated he/she "yells out during activity programs". The care plan for alteration in mood and behavior indicated the patient had discomfort at times, "seeks attention ...tearfulness, crying out. " b. The MAR and physician orders included Seroquel 25 mg orally at bedtime for "Impulse Control Disorder". Seroquel is an antipsychotic medication used to treat schizophrenia, bipolar disorder (manic depression) and major	F 329		

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 _____	04/09/2010

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 329	Continued From page 55 depressive disorder. c. An interview on 4/7/10 at approximately 1:00 PM with the Unit Manager (M) revealed the resident's Impulse Control Disorder would be exhibited by yelling out. This staff member was asked for the behavior monitoring to show any episodes of this behavior. Review of the "Mood & Behavior Record" for the time period of 8/1/09 through 4/8/10 showed only two episodes of "crying, tearfulness" (on 8/2/09 and on 10/2/09). There was no evidence of behavior monitoring since 10/2/09 to show evaluation of the effectiveness of the Seroquel. 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 and depression. a. During the survey from 4/6/10 to 4/9/10 the resident voiced complaints of pain. b. Review of the MAR 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).	F 329		

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 _____	04/09/2010

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 329	Continued From page 56 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, -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. c. There was no evidence of pain assessment when the resident experienced increased anxiety January and February nor was there evidence pain was considered as a source of the resident's behavior prior to starting Risperdal. 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. e. Behavior documentation notes from 2/17/10 indicated the resident was on the Risperdal for "Impulse Control Disorder" which had improved but still not tolerable. f. On 4/9/10 interview with the psychiatrist reported he based decisions to start medications and change a resident's medication from verbal reports from nursing staff. He indicated he did not	F 329		

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 _____	04/09/2010

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 329	Continued From page 57 assess for possible pain as a source for this resident's increase in behaviors. He indicated he would rely on the facility staff to provide appropriate pain interventions before consulting him regarding psychoactive medications. Additionally he reported the resident did have situational anxiety which could contribute to behaviors. He indicated he only considered psychoactive medications as a last resort and confirmed if behaviors were situational, behavior management interventions would be appropriate before starting or increasing psychoactive medications. He was not aware the resident had been on Darvocet N-100 1 tab TID (three times a day) which had been discontinued in Feb. (2010) which he reported can cause increase anxiety. The facility failed to ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record. (Cross refer 309)	F 329	F 332 Medication Error rate **1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #7, #8, #30 and 32 have been assessed for any problems associated with the medication error has been addressed. **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:** By changes to our system all residents will be protected. **3. What measures will be put into place or what systemic changes will you make to ensure the deficient practice will not recur:**	
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure a medication error rate of five percent or less. Medication pass demonstrated a medication error rate of 10% involving two of thirteen sample	F 332		

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 _____	04/09/2010

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 332	Continued From page 58 residents (#7 and #8) and 2 supplemental sample residents (#30 and #32), creating the potential for unwarranted medication side effects and resident discomfort. The findings included: Observation of 50 medication passes on 4/6/10, 4/7/10 and 4/8/10 revealed five errors for a medication error rate of 10%. The following medication errors were observed: 1. On 4/7/10 at 8:30 AM a Certified Medication Aide (CMA) (S) was observed during a medication pass for supplemental sample resident #30. a. The resident was given Citracal (Calcium Citrate) one tablet. Review of the MAR (Medication Administration Record) and the physician orders showed this medication was ordered and should have been given at 2:00 PM and at 8:00 PM. When the MAR was reviewed at 3:30 PM it was noted the CMA had not documented the observed, incorrect AM administration of the medication or the ordered 2:00 PM dose. The surveyor requested the medication nurse confirm with the CMA (who had ended his shift) what was given to the resident to avoid subsequent errors (i.e. a third dose of the medication). Review of the MAR Documentation Notes after the nurse had verified the CMA's medication passes indicated the CMA had given the doses in the AM and at 2 PM but had not documented these doses. b. The CMS (S) also administered Timolol eye drops (both eyes) to the resident at 8:30 AM. The medication pass observation revealed the CMA	F 332	On 5-10-10 all Licensed Nurses and Mediation Assistants were educated for the need to provide medications free of error. Included in the education was a review of the procedure for medication administrator, documentation, and the procedure for eye drops, and infection control use with eye medications. **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:** The Consultant Pharmacist will complete 2 medication reviews of staff on a monthly basis. The Pharmacist will report the results of audit to the QA/CQI Committee on an on-going basis.	

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 _____	04/09/2010

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 332	Continued From page 59 did not have the resident lean his/her head back during the application of the eye drops causing the drops to land outside of the conjunctiva. 2. On 4/6/10 at 3:45 PM a nurse (U) was observed during a medication pass for sample resident #8 a. The nurse administered NACL 5% ophthalmic Ointment to the resident's left eye. The nurse applied this ointment to the tip of a gloved finger and wiped her finger across the resident's lower eye lid. b. Facility policy regarding "Eye Medication" indicated the procedure should have the resident either lie down in bed or sit in a chair with his/her head tilted back. The policy directed staff to use a glove or gauze pad to retract the lower eyelid and to never touch the eyeball surface with the dropper of ointment tube. Further instructions indicated to instill the drops in the lower conjunctiva and have the resident close his/her eyes gently. For eye ointments the policy directed staff to "apply thin ribbon of ointment evely inside edge of lower eyelid in conjunctiva and have resident close and roll eyes around gently. 3. On 4/8/10 at 9:00 AM a nurse (D) was observed during a medication pass for supplemental sample resident #32. a. The resident was given Protonix 40 mg at 9:00 AM. Observation of this medication pass revealed the resident had received his/her breakfast. Observation of the meal showed the resident had consumed approximately half of the meal.	F 332	Staff Development will complete mediation administration audits on 1/3 of the nursing staff that administer medication. Staff will be selected so all nursing staff are audited once in a 3 month period. Problems noted in the audits will be addressed by the DNS/Designee immediately. Results of the audits will be reported to the QA/CQI Committee for 6 months and then as directed by the QA/CQI Committee. 5. **Date when corrective action, (substantial compliance), will be completed:** All Corrective Action will be completed by 5-16-10	

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 _____	04/09/2010

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 332	Continued From page 60 b. Review of the resident's MAR and the physician orders showed this medication was ordered and should have been given 30 to 60 minutes before the resident's meal. 4. On 4/6/10 at 1:25 PM, during an observation of a medication pass, CMA (B) was observed to administered Vigamox eye drops to resident #7. The CMA instilled one drop in each eye. No pressure was applied to the lacrimal duct. Review of the resident's physician orders evidenced the Vigamox eye drops were to be instilled in the "OD" (right eye). According to the Nursing 2010 Drug Handbook, page 1326, once the drops are instilled, "Place gentle pressure on lacrimal duct for 1 to 2 minutes after instilling drop".	F 332	**F 363 Ensure preparation of food according to the needs of the resident** **1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 4's nutritional status was assed to make sure his/her needs were being met and resident #4 is receiving the physician ordered pureed diet. **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:** Diet orders were reviewed for all residents by 5-16-10 and corrections made as needed. **3. What measures will be put into place or what systemic changes will you**	
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, family interview and record review, it was determined the facility failed to ensure preparation of pureed foods in accordance with the recommended dietary allowances for residents receiving puree diets and failed to ensure one of thirteen sample	F 363		

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 _____	04/09/2010

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 363	Continued From page 61 residents (#4) received his/her ordered puree diet, creating the potential for inadequate nutritional intake. The findings included: 1. On 4/6/10 at 5:58 PM the charge nurse (E) was observed to return a meal try to the kitchen. The nurse was asked who's tray was being returned and she reported it was for resident #4. The plate cover was removed which revealed noodle casserole and beets. The nurse reported for some reason the resident had not received a pureed diet. 2. 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. Review of the resident's care plan indicated he/she had chewing and swallowing problems and was on a mechanically altered diet and pudding thickened liquids. b. The resident's diet card indicated the resident was on a puree diet. 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 and she had sent it back and requested the ordered puree diet. d. Although the staff recognized the served meal was incorrect the dietary staff had no further puree food and had to prepare additional food for the resident. e. On 4/6/10 at 6:13 PM, the cook (A) was observed in the kitchen, preparing pureed meat	F 363	**make to ensure the deficient practice will not recur:** A system is in place to ensure that physician orders are communicated accurately to dietary staff and are monitored routinely for accuracy. A system is in place to ensure that all residents are monitored by the Nutrition Risk Committee routinely in conjunction with the RD and DM to ensure that needs are met through appropriate diet provision. An in-service for dietary staff was conducted on 5-10-10 by the Interim DDS on use of diet cards, menu compliance, and the importance of accuracy in meal service. **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:**	

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 _____	04/09/2010

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 363	Continued From page 62 and vegetables for resident #4. At 6:15 PM, the cook took the resident's pureed meal to him/her. 3. Review of the facility's menu evidenced the following foods were to be served to the residents on the pureed diets on 4/6/10 (evening meal) Pureed casserole or beef Soft moist roll/slurry Baked squash or Pureed vegetable Pureed salad Pureed/slurry product (cookie) a. Observation of the pureed meals served to residents evidenced they received pureed casserole and vegetables. No roll, salad or cookie was served. b. The scoops used to serve the pureed food were green handled (#12 or 2.6 ounces). The pureed menu called for a greater scoop size to be used, i.e. enough for one cup of casserole and 4 ounces of meat. c. The menu for a regular diet also called for a greater scoop size and residents were only given one scoop of casserole and one scoop of vegetables. 4. Review of the facility's menu evidenced the following foods were to be served to the residents on the pureed diets on 4/7/10 (evening meal): Pureed ham salad sandwich/slurry or summer sausage/cheese sandwich/slurry Pureed soup (turkey noodle or beef vegetable soup) Soda crackers soaked Grape juice	F 363	The DDS will monitor residents on pureed diets through observation to ensure that items are being consistently provided to each individual resident. The DDS will conduct random audits of residents with pureed diets weekly for three weeks and then on a monthly basis. 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:** All corrective action will be completed by 5-16-10	

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 _____	04/09/2010

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 363	Continued From page 63 Pureed fruit (mandarin oranges). a. Observations in the dining room evidenced that the residents who received pureed texture food received the above items and tomato soup. b. The pureed menu called for a greater scoop size to be used. The facility failed to follow the written menus as approved by the Registered Dietician. The residents on puree foods were not receiving the menued food items or the food items in the correct amount. The facility not following the menu resulted in the puree texture diet having less nutritional value. These residents on puree texture foods were at high nutritional risk and would have benefited from the increased nutritional value (calories, protein).	F 363	**F 441 Infection Control** **1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents #8 and #30 have been assessed for any eye problems related to the errors made in administration of eye medication. Resident #3 and #15 have been assessed for any signs and symptoms of infections. Any problems were addressed and the care plans updated. Residents # 8 and #30 are receiving their medications per facility procedure. The individual bottles and tubes of eye medication contaminated during the survey have been thrown away and replaced. The pill splitter has been cleaned. Resident #3 is receiving per-cares per facility procedures.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		

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 _____	04/09/2010

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 441	Continued From page 64 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure adequate infection control measures were implemented during medication administration, incontinence care and cleaning of the hydrocollator used for hot packs, creating the potential for spread of infection. This failure included observations of the care for four of thirteen sample residents (#3 and #8) and 2 supplemental sample residents (#15 and #39). The findings included: 1. Observation of medications administered to sample resident #8 and supplemental resident #30 revealed the medication nurse (U) and Certified Medication Aide (S) did not use appropriate infection control during these	F 441	**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 receive eye medications, have their pills split, are incontinent of urine, and receive hot packs have the potential to be affected in this area. All of these care areas will be monitored for infection control. The hydrocollator has been cleaned per manufactures directions and set up on a every two week clean schedule and daily temperature checks. **3. What measures will be put into place or what systemic changes will you make to ensure the deficient practice will not recur:** On 5-10-10 all Nursing Staff were educate on	

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 _____	04/09/2010

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 441	Continued From page 65 observations. a. Facility policy regarding "Eye Medication" indicated the procedure should have the resident either lie down in bed or sit in a chair with his/her head tilted back. The policy directed staff to use a glove or gauze pad to retract the lower eyelid and to never touch the eyeball surface with the dropper of ointment tube. Further instructions indicated to instill the drops in the lower conjunctiva and have the resident close his/her eyes gently. For eye ointments the policy directed staff to "apply thin ribbon of ointment evely inside edge of lower eyelid in conjunctiva and have resident close and roll eyes around gently." b. During observation of the medication pass for resident #8 revealed the nurse (U) applied eye ointment to her gloved finger to insert into the resident's eye. c. Although the nurse had donned gloves prior to instillation of the eye medications, she did not wash her hands after removing these gloves. The nurse used alcohol-based hand gel instead of washing her hands. d. During observation of the medication pass for supplemental resident #30 revealed the CMA (S) slit two medications in half per request of the resident. The CMA did not clean the pill splitter after this procedure. e. During the administration of eye drops the CMA touched the inner surface of the eyelid, which contaminates the tip of the applicator bottle. f. The resident dropped several medications in	F 441	infection control practices relating to medication administration of eye drops and eye ointments, cleaning of the pill splitter, proper incontinence care, and cleaning of the hydrocollator. The Medicare/Rehab nurse has trained the restorative assistance on the process to clean the hydrocollator. A log book will be used to document the bi-weekly cleaning. **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 ensure compliance in this area. The audit will be completed 2 X's per week for 4 weeks, then monthly for 3 months. The Staff Development/Designee, is	

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 _____	04/09/2010

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 441	Continued From page 66 his/her lap during this observation and the CMA retrieved these medications handling them with his ungloved hands. 2. On 4/8/10 at 9:55 AM, in an observation of the North Hallway medication room, a 50 ml (milliliter) vial of Lidocaine 1% 10 mg (milligrams)/ml was dated as opened on 1/17/10. On 4/8/10 at 2:15 PM, in an observation at the West Hallway nurses' station, there was a drawer which held vials of Lidocaine, normal saline, and sterile water which were open/undated or dated with a date over 30-days. 3. On 4/7/10 at 1:05 PM, nurse (K) and CNA (L) were observed toileting resident #3. When the resident's brief was removed, the staff verified that it was wet. The nurse provided peri-care to the resident after the the resident voided in the toilet. She wiped the resident's perineal area by reaching from behind the resident, using two wipes. The resident's front perineal and groin and buttocks were not cleansed. The resident's clothing was pulled up and adjusted and he/she was transferred to the wheelchair. 4. 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. The RA was asked about how often the Hydrocollator was cleaned and if a temperature log was utilized. She said that no log was kept of the temperatures and that she cleaned it four or five months ago.	F 441	responsible for the completion of the audits. The results of the audits will be reported to the QA/CQI committee for further recommendations. **5. Date when corrective action, (substantial compliance), will be completed:** All corrective action will be completed by 5-16-10	

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 _____	04/09/2010

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 441	Continued From page 67 a. On 4/8/10 at 2:50 PM, the Director of Nursing (DON) was requested to provide the manufacturer's instructions for cleaning the Hydrocollator which was located in the therapy room. Record review and staff interview confirmed that at least one resident (#15) was having these hot packs applied. b. Review of the User Manual for the facility's Hydrocollator evidenced "Regularly clean and drain the tank (every two weeks)."	F 441	**F 516 Safeguard medical records** **1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** The dietary employee who used the incorrect password no longer works at the facility and does not have any access to medical records. The Maintenance Director turned in the key to the medical records storage area 4-9-10.	
F 516 SS=E	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure protection of clinical record information against loss, destruction, or unauthorized use in storage of medical records and protection of computer access via staff passwords, creating the potential for unauthorized access to resident-identifiable health information. The findings included:	F 516	**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 employees that have computer access have the potential to be affected in this area.	

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 _____	04/09/2010

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 516	Continued From page 68 1. Review of medical records for residents showed facility staff had entered information into the electronic record using another staff member's password. In an nterview with administrator on 4/7/10 at approximately 6:15 PM he confirmed an employee in dietary was using another employee's password to record meal intakes. 2. During the environmental tour on 4/8/10 from 10:15 AM to 11:15 AM with the Maintenance Supervisor, an issue with a storage of medical records was identified. A tour of a storage area in the basement revealed a room which was being used to store medical records. The door was unlocked by the Maintenance Supervisor who reported that maintenance staff had keys to access the room which allowed access to resident medical records. He also reported he was unsure who else had keys to the room. Observation of the room revealed full length shelving units containing medical records accessible to anyone opening the door to the room. The Administrator confirmed he was unaware of who had keys and access to the room and the medical records and would follow up. The facility failed to safeguard resident medical records with the records being accessible to unauthorized persons.	F 516	**3. What measures will be put into place or what systemic changes will you make to ensure the deficient practice will not recur:** All staff will be educated on proper password usage on 5-15-10. Dietary Staff were re-educated on 4-23-10 password usage.The Maintenance Director changed the lock on the Medical Records storage so the lock is not on the master key system. Only the HIM and Administrator have keys to the Medical Records Storage Area. **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 will audit 4 nursing and 4 dietary staff every month.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520		

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 _____	04/09/2010

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 520	Continued From page 69 QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure quality assessment and assurance interventions for the investigation and development of a system to prevent burns from hot liquid spills. The findings included: In an interview on 4/8/10 at approximately 2:30 PM with the nursing staff (R) who was responsible for QA activities, she indicated the	F 520	The audits will include proper password usage. 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:** All Corrective Action will be completed by 5-16-10 **F 520 Quality Assurance Committee** **1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** The QA/CQI Committee has developed a plan to prevent burns from hot liquid spills	

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 _____	04/09/2010

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 520	Continued From page 70 facility had various QA activities. However she indicated there was no QA activity conducted to address the burns from hot coffee were initially identified on 8/12/09. Subsequent coffee spills or burns occurred on 2/18/10 (resident #2) and 3/31/10 (Resident #10). The QA nurse indicated the only reference in QA minutes (11/19/09) related to an Activity worker who was burned with hot coffee. A Food Temperature Focus Audit had been completed on 5/19/09 but this audit did not show the temperature of any coffee or other hot beverage. The facility's QA process failed to develop and implement plans of action to correct and prevent further burns (Cross Reference §483.25(h) Accidents (F323) for resident specifics).	F 520	**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:** By changing the system all residents will be protected **3. What measures will be put into place or what systemic changes will you make to ensure the deficient practice will not recur:** The temperature on the coffee dispenser was lowered by 30 degrees. The machine now dispenses coffee at 135 degrees. Residents have accepted the lower temperature with no complaints. Dietary has ordered a thermal carafe to dispense hot coco at 135 degrees. **See Attached Addendum**	

Addendum for POC for Survey completed on 4-9-10

F 520 QA (continued from page 71 of 71)
Special cups with lids on will be used for residents who have been assessed as unsafe to have hot liquids. All Staff have been educated on the need to protect residents from hot liquid spills. Education included a written test.

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:**
   The DDS will conduct 3 random audits by observing residents in the dining room to ensure that needs have been addressed. This audit will be conducted weekly for 4 weeks, the monthly for 2 months. The audit results 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:**
   All Corrective Action will be completed by 5-16-10