STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 10/04/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the complaint survey, conducted October 3-4, 2012, the sample included (6) six residents for complete review, (7) seven residents for *focused review*, and (2) two closed records for review.	F 000	**General *Disclaimer*** Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide assistive devices necessary to prevent accidents for 1 of 6 sampled residents (Resident #2) and 5 supplemental residents (Resident #9, #11, #12, #14, and #15) observed without wheelchair foot pedals in place. Failure to apply foot pedals to wheelchairs during staff-assisted transport may result in falls and/or injuries to residents. Findings include: - Review of Resident #2's medical record occurred on October 3-4, 2012. Diagnoses included cerebral vascular disease (stroke) and pain. The current quarterly Minimum Data Set (MDS), dated 08/10/12, identified moderately impaired cognition and extensive assistance of	F 323	**F323-Free of Accident Hazards/Supervision/Devices** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** A storage bag for wheelchair pedals was placed on the back of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark D Hartley — TITLE: Administrator — (X6) DATE: 11/07/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 10/04/2012

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 1 one person for transfers and limited assistance of one person for locomotion on the unit. Review of an incident report for Resident #2 on 09/17/12 at 7:20 a.m. stated, "Res [resident] was in w/c [wheelchair] certified nursing assistant [CNA] was assisting res [with] w/c mobility. Res put feet down and feet stuck. Res went forward and went out of the chair to the floor, [CNA] tried to catch res unable to stop res from tipping forward and going to the floor. [Neurochecks] starting." During an interview on 10/03/12 at 5:00 p.m., Resident #2, identified as interviewable by the facility, stated "most times [staff] push me [in wheelchair], sometimes make me walk" and stated, "No," staff do no use foot pedals on wheelchair. - Review of Resident #11's medical record occurred on October 3-4, 2012. Diagnoses included pain. The current quarterly MDS, dated 09/07/12, identified severely impaired cognition and extensive assistance of two persons for transfers and extensive assistance of one person for locomotion on the unit Observation on 10/03/12 at 5:00 p.m., showed a CNA (#1) transported Resident #11 to the dining room in his wheelchair without foot pedals. During the transport, Resident #11's feet brushed along the floor. Observation on 10/04/12 at 8:35 p.m., showed a CNA (#1) transported Resident #11 to his room in his wheelchair without foot pedals. During the transport, Resident #11's feet bounced on the	F 323	Resident #2's wheelchair to remind staff to use the pedals and to have the pedals easily available. A storage bag for wheelchair pedals was placed on the back of Resident #11's wheelchair to remind staff to use the pedals and to have the pedals easily available. A storage bag for wheelchair pedals was placed on the back of Resident #9's wheelchair to remind staff to use the pedals and to have the pedals easily available. A storage bag for wheelchair pedals was placed on the back of Resident #12's wheelchair to remind staff to use the pedals and to have the pedals easily available. A storage bag for wheelchair pedals was placed on the back of Resident #14's wheelchair to remind staff to use the pedals and to have the pedals easily available. Update care plans. **Completed for all residents 11-6-12**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 10/04/2012

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 2 floor. Observation showed foot pedals stored in a bag attached to the back of the resident's wheelchair. - Review of Resident #9's medical record occurred on October 4, 2012. Diagnosis included vertigo and pain. The current quarterly MDS, dated 08/25/12, identified severely impaired cognition and extensive assistance of one person for transfers and locomotion on the unit. Observation on 10/04/12 at 9:00 a.m., showed a restorative nursing aide (#4) transported Resident #9 from the dining room back to her room in her wheelchair without foot pedals. During the transport, Resident #9's feet brushed the floor. - Review of Resident #12's medical record occurred on October 4, 2012. Diagnoses included cerebral vascular disease and pain. The current quarterly MDS, dated 08/08/12, identified long term memory problems and extensive assistance of one person for transfers and locomotion on the unit. Observation on 10/04/12 at 10:40 a.m., showed a CNA (#2) transported Resident #12 from the nurse's station to the doors of the dining room in his wheelchair without foot pedals. During the transport, Resident #12's feet brushed the floor. - Review of Resident #15's medical record occurred on October 4, 2012. Diagnosis included pain, anxiety, and Alzheimer's disease. The current quarterly MDS, dated 07/06/12, identified severely impaired cognition and extensive assistance of one or two persons for transfer and one person for locomotion on the	F 323	**This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** The Rehab Nurse Supervisor has reviewed care plans and identified all residents who use a wheelchair for mobility yet use wheelchair pedals intermittently. A storage bag for wheelchair pedals was placed on the back these wheelchairs to remind staff to use the pedals and to have the pedals easily available. The Rehab Nurse Supervisor/Designee will identify the wheelchairs of residents needing intermittent wheelchair pedal usage so other staff can help ensure pedals are available **Completed 11-6-12** **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** Nursing Staff were educated on the requirement of using wheelchair pedals when ever transporting residents in a wheelchair. Nursing Staff were educated to use the storage bags to keep wheelchair pedals readily available for use when transporting residents who	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 10/04/2012

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 3 unit. Observation on 10/04/12 at 8:50 a.m., showed a CNA (#3) transported Resident #15 from the dining room to the nurse's station in his wheelchair without foot pedals. During the transport, Resident #15's feet brushed the floor. - Review of Resident #14's medical record occurred on October 4, 2012. Diagnosis included cerebral vascular accident (CVA), impulse control disorder, and osteopenia. The quarterly MDS, dated 09/15/12, identified moderately impaired cognition and total dependence for locomotion on/off the unit. Observation on 10/04/12 at 8:45 a.m. showed, a managerial staff member (#6) transported Resident #14 in her wheelchair from the dining room to her room. The toe area of Resident #14's left slipper slid along the surface of the flooring as the managerial staff member (#6) transported her down the hallway. The resident did not lift her left foot. The managerial staff member #6 failed to ensure both of the resident's feet cleared the floor during transport, and failed to either remind the resident to lift both of her feet or place foot pedals on her wheelchair. During an interview on 10/04/12 at 9:05 a.m., an administrative nursing staff member (#5) stated, "If staff assist the resident down the hallway, they have to put pedals on the wheelchair."	F 323	use wheelchair pedals in an intermittent basis. Completed 11-6-12 All staff were educated on the need to provide wheelchair pedals while assisting residents in wheelchairs. Education was completed using posters, written information and written testing. The Director of Workforce Development will be responsible to ensure all staff are trained. **Completed 11-14-12** **This is how the facility will monitor to make sure the changes continue and the problem is prevented.** An audit will be developed to ensure compliance in this area. The audit will include direct observation of staff using proper wheelchair pedals during a resident transport, to make sure wheelchair pedals are stored in the storage bags on the back of the wheelchairs, and wheelchairs are identified so staff know which residents are needing intermittent wheelchair pedal use. **Continued on next page labeled "A"**	

Page "A"

Continuation of Plan of Correction
for Survey Completed on 10/04/2012
for provider number 355100, Good
Samaritan Society-Devils Lake

The Rehab Nurse
Supervisor/Designee will complete 3
audits per week for 4 weeks, then
weekly for 4 weeks, then monthly
for one month
The Rehab Nurse
Supervisor/Designee will be
responsible to complete the audits.
A report of the audits will be
submitted to the Continuous Quality
Improvement (CQI) Committee for
further recommendations.
Completed 11-14-12

Tanja Suggerman, DON
11/19/12 @ 9:03 am
via phone