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 _____	01/23/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 01/21/14 and completed on 01/23/14, the sample included two (2) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review. The sampled included three (3) additional residents to verify specific concerns during the survey.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the 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 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, resident interview, and staff interview, the facility failed to provide care for residents in a manner and in an environment which maintained or enhanced each resident's dignity for 4 of 11 sampled residents (Resident #2, #3, #9, and #10) and 2 supplemental residents (Resident #14 and #15). Failure to cover/store or empty bedside commodes (Resident #2 and #9), clean expectorated secretions from a dependent resident's face (Resident #14), and knock before entering resident rooms (Resident #3, #10 and #15) does not maintain or enhance the residents' dignity. Findings include: Review of the "Bedpan, Urinal, and Commode"	F 241	F 241 Part 1 of 3 Residents # 2 and #9 will have their individual need addressed by having the bedside commodes covered, stored, and emptied according to facility procedure. Part 2 of 3 Residents' # 14 individual needs have been addressed by educating staff and care planning to frequently wipe off	5. 2-27-2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan E Beeman — TITLE: Administrator — (X6) DATE

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

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F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, resident interview, and staff interview, the facility failed to provide care for residents in a manner and in an environment which maintained or enhanced each resident's dignity for 4 of 11 sampled residents (Resident #2, #3, #9, and #10) and 2 supplemental residents (Resident #14 and #15). Failure to cover/store or empty bedside commodes (Resident #2 and #9), clean expectorated secretions from a dependent resident's face (Resident #14), and knock before entering resident rooms (Resident #3, #10 and #15) does not maintain or enhance the residents' dignity. Findings include: Review of the "Bedpan, Urinal, and Commode"	~~F 244~~ F-241	F 241 Part 1 of 3 Residents # 2 and #9 will have their individual needs addressed by having the bedside commodes covered, stored, and emptied according to facility procedure. Part 2 of 3 Residents' # 14 individual needs have been addressed by educating staff and care planning to frequently wipe off	2/27/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan E Dorgland — TITLE: Administrator — (X6) DATE: 2/19/14

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

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F 241	Continued From page 1 policy occurred on the afternoon of 01/23/14. The policy, dated September 2012, stated ". . . Rinse commode with water and clean thoroughly, using a disinfectant. Sanitize weekly. Dry with paper towels; store in designated area. . . ." - The initial facility tour of the facility occurred on 01/21/14 at 12:45 p.m. and identified the following: * An uncovered bedside commode near the foot of Resident #2's bed. The room presented with a foul urine odor and the commode contained a small amount of urine. The commode sat in full view of any visitors, residents, or staff passing by the room. * An uncovered bedside commode near Resident #9's bed. The room presented with a urine odor. Observation throughout the day on 01/22/14 and on 01/23/14 at 8:00 a.m. showed the bedside commode remained in Resident #2's room near the end of the bed, in full view from the hall. Observation on 01/22/14 at 5:00 p.m., and on 01/23/14 at 9:15 a.m., showed the uncovered bedside commode remained near Resident #9's bed. During an interview on 01/23/14 at 8:30 a.m., two administrative nurses (#1 and #2) stated the bedside commode should be stored in the bathroom when not in use. - During an interview on 01/22/13 at 5:05 p.m., Resident #10 stated the facility staff knock but they don't wait for a response before entering. - Observation on 01/23/14 at 9:40 a.m., showed the nurse (#2) entered Resident #3's room. The	F 241	the oral expectorated secretions from his face. Part 3 of 3 Residents # 3, #10, and #15 individual needs are being met by having staff members knock before entering resident rooms. 2. All residents have the potential to be affected in these areas. By educating and auditing the staff no additional residents will be affected. 3. A mandatory nursing inservice will be held on 2-19-2014 to educate the staff on the procedure titled: Bedpan, Urinal, and Commode. Staff were educated to rinse commodes with water and clean thoroughly, using a disinfectant sanitize weekly. Dry with a paper towel in a designated area. Also staff received education on the need to keep faces clean from expectorated secretions and to provide privacy by knocking and asking permission to enter before entering the resident rooms. 4. An audit will be developed to monitor if bedside commodes are covered, cleaned, and stored appropriately, if faces are free from oral expectorated secretions, and if	

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F 241	Continued From page 2 nurse failed to knock or announce herself prior to entering the room. - Observations during medication administration on 01/22/14 showed the following: * 9:15 a.m. - The nurse (#10) entered Resident #14's room with his morning medications. Two unidentifed certified nursing assistants were in the room and stated they would "clean him up" when the nurse finished administering the medications. Observation showed expectorated secretions on the resident's face, neck, and clothing. The nurse (#10) wiped Resident #14's face before she began the medication administration via gastostomy tube (feeding tube). During the administration, the resident coughed and expectorated more secretions which ran down his face, chin, and neck. The nurse completed the medication administration and left the room. The nurse (#10) failed to clean Resident #14's face before leaving the room. * 9:35 a.m. - Observation showed Resident #15's door to her room open and her back to the door. The nurse (#10) entered the room without knocking and tapped the resident on the shoulder. Resident #15 startled and the nurse said "I'm sorry" and stated she needed to administer her eye drops.	F 241	staff knock before entering residents' rooms. The audit will be completed by the DNS or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the QA committee for further recommendations. 5. 2-27-2014	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280	F 280 Part 1 of 2 Part 1 Resident's # 3, #5, and # 8 will have their individual needs met by updating the care plan to include weight loss	2/27/14

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F 280	Continued From page 3 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON JANUARY 16, 2013. Based on observation, record review, and staff interview, the facility failed to review and revise the plan of care for 3 of 11 sampled residents (#3, #5, and #8). Failure to update the care plan related to weight loss and fortified foods (Resident #3, #5, and #8) and behaviors with toileting (Resident #5) limited the staff's ability to provide care in a consistent and coordinated manner. Findings include: - Review of Resident #5's medical record occurred on all days of survey. The dietary progress notes identified the resident experienced a significant weight loss and fortified foods and Ensure pudding (a nutrition supplement) were added to his diet.	F 280	and nutritional interventions including fortified foods. Part 2 Resident #5's individual needs have been met by care planning behaviors associated with toileting which could result in UTI's. Care plan updated to offer to toilet resident and if he continues to refuse, to lay him down in bed, check the brief, if incontinent change brief and provide adequate pericare every two hours or as he allows. 2.All residents that have significant or insidious weight loss have the potential to be affected in this area will have their care plan reviewed for nutritional risk and individualized interventions to maintain adequate nutrition. All residents with documented behaviors related to toileting and residents that staff verbalize as having behaviors with toileting have the potential to be affected in this area. The care plans will be reviewed to ensure there is a care plan for toileting with behaviors and a plan on how staff will provide adequate pericare.	

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F 280	Continued From page 4 Resident #5's care plan related to nutrition stated, "Pot [potential] for alt [alteration] in nutrition R/T [related to] debility, dementia . . . Plans and Approaches: Level 3 regular diet [cut or ground meats] with toast only, no bread. Feeds self, encourage to finish meal." The care plan failed to to include the resident's weight loss and the addition of dietary interventions. Observation on 01/22/14 at 8:51 a.m. and on 01/23/14 at 9:05 a.m., showed a Certified Nursing Assistant (CNA) (#11) attempted to assist Resident #5 into the bathroom. Both times the resident refused ant stated, "get that thing out of here," and pointed to the mechanical lift and, "no, no, leave me alone." The CNA (#11) stated it is challenge to get Resident #5 into the bathroom and the best time to take him is in the morning when he wakes up and at bedtime. She stated sometimes it's easier to check and change his brief when he is lying down. Resident #5's care plan related to toileting stated, ". . . has bladder incontinence R/T dementia . . . frequently incontinent of bladder . . . Interventions: . . . Turn and reposition every 2 to 2 1/2 hours and PRN [as needed." The care guide (a condensed version of the care plan utilized by the CNAs) stated, "Toilet every 2 to 2 1/2 hours while restrained to promote continence." Resident #5 utilized a wheelchair which prevents him from rising. The care plan failed to include Resident #5's behaviors related to toilet use and conflicted with the CNA (#11's) statement. - Review of Resident #8's medical record occurred on January 22-23, 2014. The dietary progress notes identified the resident experienced a significant weight loss and fortified	F 280	3. A mandatory nursing inservice will be held on 2-19-2014 to educate the staff on the need to care plan when a resident refuses to use the toilet or has behaviors which could results in inadequate pericare which could lead to UTI's. A mandatory Dietary meeting was held on 2-18-2014 to educate the staff on the new menu with fortified foods extensions and the need to follow the tray card for nutritional interventions. System change: Dietician report form: GSS #458 Nutrition risk list is completed by the RD and then routed to all department heads for review. 4. An audit will be developed to monitor care plan interventions for weight loss and fortified foods and if the care plan addresses interventions for behaviors associated with toileting. The audit will be completed by the DNS or designee weekly for four weeks, then monthly for three months. The results of the audits will be reported to the QA committee for further recommendations.	

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F 280	Continued From page 5 foods and Ensure pudding were added to her diet. Resident #8's care plan related to nutrition stated, "Pot for alt in nutrition R/T dementia . . . Level 4 regular diet [regular]." The care plan failed to to include the resident's weight loss and the addition of dietary interventions. - Review of Resident #3's medical record occurred on all days of survey. The current physician orders stated, "Regular diet Regular texture, Regular fluid consistency, with Fortified Foods level 3 meats (cut up)." Resident #3's care plan stated, " . . . Level 4 Regular Diet . . . " Resident #3's care plan failed to identify a level 3 diet as ordered. During an interview on the afternoon of 01/23/14, two administrative nurses (#1 and #2) agreed the care plans were not accurate.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and review of facility policy, the facility failed to provide the necessary care and services to manage behavioral	F 309	F 309 Resident #4's individual needs have been addressed by updating the care plan to include interventions of attempting and documenting non pharmacological interventions prior to administering her Ativan, such as warm blankets, snack, diversion,	2/27/14

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F 309	Continued From page 6 symptoms for 1 of 1 sampled resident (Resident #4) identified by the facility with behaviors and received as needed (prn) Ativan (an anxiolytic). Failure to identify the reason/causative factors for behaviors and attempt nonpharmacological interventions prior to administering Ativan has the potential for Resident #4 not to obtain her highest practicable physical, mental, and psychosocial well-being. Findings include: Review of the facility policy titled "Psychoactives" occurred on 01/23/14. The policy, dated January 2006, stated, ". . . While the use of prn psychoactive medications is not encouraged, if a prn Physicians' order is received, ensure that the order has clear parameters, i.e. severe agitation that does not respond to other care plan interventions. It is important to initiate other care plan interventions prior to the use of prn psychoactive medications. . . ." Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia with behaviors. The current care plan stated, ". . . The resident has a behavior symptom R/T [related to] dementia E/B [evidenced by] combative with cares and rejects cares. . . . approach in a calm and consistent manner. . . . reapproach resident and give her a time to calm down and don't rush her. . . . The resident has potential to be resistive with cares R/T [related to] dementia with psychotic behaviors E/B antipsychotic therapy daily. . . . Provide consistency in care to promote comfort . . . If resident resists with ADLs [activities of daily living], reassure resident, leave and return 5-10 minutes later and try again. . . .	F 309	message, 1:1 conversation or soft music or TV. The documentation of these non pharmacological interventions is located on the MAR. 2.All residents that receive PRN Ativan have the potential to be affected in this area. A list of residents on PRN psychoactive medications (including Ativan) will be generated and each resident listed will have the care plan interventions reviewed for documentation of the attempting to provide non pharmacological interventions prior to administering PRN psychoactive medications. 3. A mandatory nursing inservice will be held on 2-19-2014 to educate the staff on the procedure titled "Psychoactive Medications" and the need to attempt and document non pharmacological attempts on the E-MAR prior to administering PRN psychoactive medications. 4. An audit tool will be created to monitor staff documentation of non pharmacological interventions prior to administering PRN psychoactive medications. The audit will be	

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F 309	Continued From page 7 NON-PHARMACOLOGICAL: Attempt non-pharmacological interventions approach resident in calm manner, redirect, if resistive reapproach in 5-10 minutes. . . ." Current medications included Ativan 0.25 milligrams (mg) every six hours prn. Since the initiation of prn Ativan on 10/15/13, the record identified staff administered it four times: 11/06/13, 12/15/13, 12/23/13, and 01/21/14. Nurses' notes identified the following: *01/21/14 at 8:23 a.m.: ". . . Ativan Tablet . . . increased aggitation [sic], crying, yelling . . ." *12/23/13 at 8:00 a.m.: ". . . Ativan Tablet . . . yelling with increased aggitation [sic] . . ." *12/15/13 at 9:02 a.m.: ". . . Ativan Tablet . . . increased aggitation [sic] et [and] yelling . . ." *12/15/13 at 2:49 p.m.: ". . . This am [morning] resident was heard across the facility as she screamed during ADL's [activities of daily living]. two CNA's [certified nursing assistants] were with her as her aggitation [sic] increased. Was given PRN Ativan and the aggitation [sic] decreased. Approximately 1400 [2:00 p.m.] resident was sliding out of her WC [wheelchair]. CNA et TX [treatment] Nurse attempted to reposition, resident hissed at them et began to scream again. . . ." Resident #4's "Mood and Behavior Report," dated 12/15/13, identified "Visit 1:1 [one to one] with the resident" as an intervention for the resident's agitation/rejection of cares. The record lacked evaluation of possible precipitating factors for these behaviors, as well as evidence staff attempted other inventions (such as reapproaching) as outlined in Resident #4's care plan. "Mood and Behavior Reports," as well as	F 309	completed by the DNS or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the QA committee for further recommendations. 5. 2-27-2014	

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F 309	Continued From page 8 nurses' notes dated 01/21/14 and 12/23/13, also failed to identify possible precipitating factors/non-pharmacological interventions attempted. The facility failed to assess the possible triggers/causes for Resident #4's increased agitation/yelling and attempt nonpharmacological interventions prior to administering Ativan. Failure to identify possible causative factors which precipitated behaviors does not allow the facility to look for patterns in Resident #4's behaviors or develop and implement creative individualized interventions to decrease the behaviors.	F 309		
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, record review, and staff interview, the facility failed to provide the necessary assistance with activities of daily living (ADLs) for 1 of 3 sampled residents (Resident #7) who required staff assistance with perineal care and application of compression stockings (i.e. TED hose). Failure to provide complete perineal cares may result in skin irritation/breakdown. Failure to apply TED hose as ordered may result in increased edema. Findings include:	F 312	F 312 1. Resident # 7 is receiving pericare appropriately to avoid skin irritation and is wearing the TED stockings as ordered by the MD to prevent lower extremity edema. 2. All residents that require assistance with pericare have the potential to be affected in this area and all residents that wear TED stockings have the potential to be affected in this area. A list of residents that require assistance with toileting will be generated and these residents will be audited to ensure adequate peri care is being delivered to prevent irritation and skin breakdown and UTI's. A list of residents with TED stockings will be generated and audited for appropriate application of on in the	2/27/14

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F 312	Continued From page 9 Review of Resident #7's medical record occurred on all days of survey. Diagnoses included cerebrovascular accident (CVA), hemiplegia, hypertension (HTN), benign prostatic hypertrophy (BPH), and a history of urinary tract infections (UTI's). The current Minimum Data Set (MDS), dated 11/03/13, identified extensive assistance from one person for dressing and personal hygiene, frequent urinary incontinence, and occasional bowel incontinence. Current physician's orders included "TED hose on in a.m. and off at night daily." Resident #7's current care plan stated, ". . . The resident has altered cardiovascular status R/T [related to] HTN . . . CAD [coronary artery disease] . . . E/B [evidenced by] antihypertensive medication and diuretic therapy daily. . . . Support stockings: On AM and OFF HS [bedtime] daily. . . . The resident has an ADL [Activities of Daily Living] self care performance deficit R/T CVA . . . E/B extensive assist of one with ADLs. . . ." Observation on 01/21/14 at 4:37 p.m. showed a Certified Nursing Assistant (CNA) (#3) assisted Resident #7 to the bathroom. The resident was incontinent of urine. The CNA wiped the resident's buttocks with toilet paper, but failed to provide front perineal care/cleansing. Observation on 01/22/14 at 4:05 p.m. showed a CNA (#4) assisted Resident #7 to the bathroom. The resident was incontinent of urine. The CNA wiped Resident #7's buttocks with toilet paper, but failed to provide front perineal care/cleansing. Observations throughout the day on 01/22/14 showed facility staff failed to apply Resident #7's	F 312	morning and off at HS to prevent lower extremity edema. 3. A mandatory nursing inservice will be held on 2-19-2014 to educate the staff on the procedure titled "Perineal Care" and "Elastic Bandages and Stockings" to ensure adequate incontinence care is performed to prevent irritation and skin breakdown and to make sure that resident with physician orders for TED stockings have them on in the morning and off at HS to prevent lower extremity edema. 4. An audit tool will be developed to monitor both adequate perineal care for residents that require assistance from staff and also to ensure TED stockings are applied as ordered by the physician to prevent increased edema in the lower legs. The audit will be completed by the DNS or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the QA committee for further recommendations. 5. 2-27-2014	

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F 312	Continued From page 10 TED hose, although staff indicated on the treatment administration record (TAR) the TED hose had been applied. During an interview on the afternoon of 01/23/14, a supervisory nurse (#1) agreed staff should clean the front perineal area as well as the back during perineal cares.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON JANUARY 16, 2013. Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to provide the necessary treatment and services to aid in prevention and promote healing of a pressure ulcer for 1 of 1 sampled resident (Resident #3) with a facility acquired unstageable pressure ulcer. Failure to identify, develop, and implement all necessary interventions may have contributed to the development and delayed healing of the pressure ulcer.	F 314	F 314 1. Resident #3's individual needs have been met by identifying and communicating with dietary the wound on the right heel, updating the care plan to include floating the heel off the bed to reduce pressure, by wearing heel booties on at all times, and to provide fortified foods with meals. 2. All residents with open areas have the potential to be affected in this area. All residents listed will have their care plan reviewed to ensure a care plan problem has been started, communicated with dietary, and have documented weekly skin inspections for all residents. 3.A mandatory nursing inservice will be held on 2-19-2014 to educate the staff on the procedure titled 'Pressure Ulcers', to educate the staff on the need for daily CNA skin inspections with routine cares, weekly documented skin inspections by	2/27/14

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F 314	Continued From page 11 Findings included: Review of the facility policy titled "Pressure Ulcers" occurred on 01/23/14. This policy, dated 2007, stated, ". . . the center will utilize prevention and assessment interventions to ensure that a resident entering the center without pressure ulcers does not develop a pressure ulcer unless the individual's clinical condition demonstrated that this was unavoidable." Review of the facility procedure titled "Skin Assessment and Pressure Ulcer Prevention occurred on 01/23/14. This revised policy, dated 01/14, stated, " . . . Procedure: . . . 5. A systematic skin inspection will be made daily by the nursing assistant to those residents at risk for skin breakdown . . . 7. If a pressure ulcer is identified . . . 10. Notify dietary of the pressure ulcer . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses included cerebral vascular accident (stroke) with right hemiplegia, pressure ulcer of the heel, and dementia. The quarterly Minimum Data Set (MDS), dated 12/13/13, identified the resident required extensive assistance for bed mobility, transfers, toileting, and personal hygiene, and an unstageable pressure ulcer. Resident #4's current care plan stated, " . . . Focus: The resident has actual impairment to skin integrity R/T [related to] Right hemiplegia E/B [evidenced by] unstageable area to Right Heel. . . . Interventions: . . . elevate heels off bed. . . . Resident needs protection for the feet bool [sic] heel booties on at all times. . . ."	F 314	licensed nurse, identification and communication of residents with pressure ulcers to dietary, ensuring each resident is reviewed by the RD timely. The care plan problem will be reviewed to ensure it addresses the skin issues with individualized care plan approaches to reduce and prevent pressure ulcers. 4.An audit tool will be developed to monitor if the weekly skin inspection was done and documented, any areas of pressure are communicated with Dietary, if the Registered Dietician has been informed, and the care plan has been updated for nutritional interventions such as fortified foods for all residents with open pressure ulcers. The audit will be completed by the DNS or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the QA committee for further recommendations. 5.2-27-2014	

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Resident #3's progress notes stated:
* 11/28/2013- 11:47 "When arriving on Day shift night nurse reported escar [sic] [dry necrotic tissue] area on resident's right heel. Upon assessment found a 5 1/2 x [by] 2 1/2 cm [centimeter] escar [sic] to right heel. Elasto-gel dressing with mefix [tape] applied for protection, shoes and socks removed from heel and pressure relieving boots applied to both feet. MD [medical doctor] faxed in regards to heel and treatment plan . . ."
* 11/28/2013- 13:50 "Resident found to have unstageable pressure to right heel. Elastogel applied and physician notified, orders given. Blue heel booties applied and sock removed from heel. Resident also given hydrocodone PRN [as needed] for some increased pain. . . ."

Resident #3's nutritional status progress notes identified the following:
* 12/19/13- Nutrition Risk: "Gradual weight loss and low BMI [body mass index] . . . Level 4 diet with fortified foods and supplement prn. . ."
* 01/09/14- "Low BMI . . .Level 4 diet with fortified foods and 240cc [cubic centimeter] supplement prn. . . . Sits at assist table. . . . Resident likes the ensure plus so will fax to Dr for 120 cc ensure plus at AM & PM snacks. . . ."
* 01/09/14-" Rec'd [received] and observed new order from Dr. [name] for Ensure Plus 120cc BID [twice a day] For Low BMI."

During an interview on 01/23/14 at 10:05 a.m., a staff dietitian (#8) stated staff notified her on 01/09/14 of Resident #3's skin issues. The dietitian recommended a supplement twice a day as the resident already received fortified foods.

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F 314	Continued From page 13 Observation on 01/22/14 at the noon meal identified Resident #3 eating chicken, baked potato with sour cream, and carrots. Resident #3's tray card identified "fortified food." An interview during the meal with the dietary manager (#5) identified mashed potatoes as the fortified food item. During an interview on 01/22/14 at 12:15 p.m. two dietary cooks (#6 and #7) stated Resident #3 does not receive fortified foods. The cook (#7) looked at Resident #3's dietary tray card and stated he is not on fortified foods. This contraindicated what the tray card stated. During an interview at 12:35 p.m., a dietary manager (#5) identified Resident #3 received fortified food due to weight loss and skin issues. This staff member confirmed the tray card said "fortified food." He further stated Resident #3 preferred a baked potato and staff should add extra butter and sour cream to the baked potato. The staff failed to add butter or extra sour cream to the potato. Observation on 01/21/14 from 3:30 p.m. until 5:10 p.m. showed Resident #3 lying in bed with bilateral heel boots on, the resident's heels were resting directly on the bed. Staff failed to elevate the resident's heels off the bed (float heels) as per Resident #3's care plan. Observation on 01/23/14 at 9:40 a.m. showed Resident #3 positioned slightly on his left side with a pillow under his knees. The resident's heels rested directly on the bed. During an interview on 01/23/14 at 9:40 a.m. in Resident #3's room, an administrative staff	F 314		

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F 314	Continued From page 14 member (#2) confirmed the resident's heels were not floated and the staff member repositioned Resident #3's heels so they did not touch the bed. Staff failed to identify resident #3's right heel pressure ulcer until it progressed to 5 1/2 x 2 1/2 cm in size. Observation showed the staff failed to float the resident's heel and failed to provide Resident #3 with fortified foods. The facility failed to notify the staff dietician of the pressure ulcer until 42 days after identifying the ulcer.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure for 1 of 1 sampled resident (Resident #5) frequently incontinent of urine received appropriate treatment and services to maintain as much bladder continence as possible. Failure to provide Resident #5 with toileting per his schedule resulted in incontinence and may affect his dignity and self-esteem.	~~F 315~~ F315	F 315 1.Resident #5's individual needs have been met by care planning behaviors associated with toileting which could results in UTI's. Care plan was updated to offer to toilet resident and if he continues to refuse to lay him down in bed, check the brief, if incontinent change the brief and provide adequate pericare every two	2/27/14

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F 315	Continued From page 15 Findings include: Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia, weakness, and a history of urinary tract infections (UTIs). The resident's quarterly Minimum Data Set (MDS), dated 12/21/13, identified both long and short term memory problems, frequently incontinent of bowel and bladder, required extensive assistance of two or more staff for toileting needs, and a restraint (chair which prevents rising) used daily. Resident #5's care plan related to toileting stated, ". . . has bladder incontinence R/T dementia . . . frequently incontinent of bladder . . . Interventions: . . . Turn and reposition every 2 to 2 1/2 hours and PRN [as needed]." The care guide (a condensed version of the care plan utilized by the Certified Nursing Assistants (CNAs)) stated, "Toilet every 2 to 2 1/2 hours while restrained to promote continence." - Observation on 01/22/14 at 8:51 a.m. showed a CNA (#11) attempted to assist Resident #5 into the bathroom. The resident refused and stated, "get that thing out of here," and pointed to the mechanical lift. The CNA stated it is challenge a to get Resident #5 into the bathroom and she would try again later. - On 01/22/13 at 9:45 a.m., a CNA/bath aide (#12) transported Resident #5 into the shower room for a bath. Observation showed the resident's brief saturated with urine. Review of the voiding report and observations from 10:00 a.m. to 6:20 p.m., showed facility staff failed to assist Resident #5 to the toilet until later that evening when the night staff documented a large	F 315	hours or as he allows to prevent UTI's. 2.All residents with documented behaviors related to toileting and residents that staff verbalize as having behaviors with toileting have the potential to be affected in this area. The care plans will be reviewed to ensure there is a care plan for toileting with behaviors and a plan on how staff will provide adequate pericare. 3. A mandatory nursing inservice will be held on 2-19-2014 to educate the staff on the need to care plan when a resident refuses to use the toilet or has behaviors which could results in inadequate pericare which could lead to UTI's. In addition, staff were educated on the procedure titled "Perineal Care" which reviewed proper incontinence care to prevent irritation and UTI's. 4. An audit will be developed to monitor if the care plan addresses interventions for behaviors associated with toileting as well as proper incontinence care. An audit tool will be developed to review appropriate	

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F 315	Continued From page 16 incontinent void. - Observation on 01/23/14 at 9:05 a.m. showed a CNA (#11) attempted to assist Resident #5 into the bathroom. The resident refused and stated, "no, no, leave me alone." The CNA (#11) stated the best time to take him is in the morning when he wakes up and at bedtime. She stated sometimes it's easier to check and change his brief when he is lying down. Failure to ensure Resident #5 received necessary assistance to the bathroom could result in UTIs, skin breakdown, and a loss of comfort/dignity.	F 315	pericare for individuals who need assistance. The audits will be completed by the DNS or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the QA committee for further recommendations.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide supervision and assistive devices necessary to prevent accidents for 2 of 6 sampled residents (Resident #4 and #7) identified with falls. Failure to consistently implement fall prevention measures (i.e. lap belts and door alarms) may result in avoidable falls and injuries. Findings include:	F 323	F 323 Resident #4's individual needs have been met by reviewing the physical restraint assessment for the effectiveness of the lap belt and ensuring the lap belt is in place when up in the w/c. Resident #7's individual needs have been met by discontinuing the personal alarm. Resident no longer attempts to transfer to the toilet independently. 2. A list of residents that have personal alarms due to behaviors associated with using the bathroom or with toileting will be generated and	2/20/14

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F 323	Continued From page 17 - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia, osteoarthritis, and a history of falls. The current care plan stated, ". . . The resident uses physical restraints R/T [related to] dementia, Hx [history] of falls E/B [evidenced by] resident unable to release belt. . . . Interventions . . . Provide a meaningful program of activities that accommodates restraint use without drawing unwanted attention. Provide restraint-free time during activities when possible to supervise closely. . . . Apply safety lap belt when up in wheelchair. Release every 2 hours. . . ." An "Incident Report," dated 11/29/13, stated, ". . . Location of Incident: Activity Room . . . Alleged Nature of Incident: Leaning over towards floor, fell forward . . . Comments: . . . Heard residents alarm go off, looked over at her, seen her trying to pick something up from the floor, then immediately flip over onto the floor. . . ." A fax to the physician, dated 11/29/13, stated, ". . . Res. [Resident] leaned over in lounge [and] tumbled out of W/C [wheelchair]. Witnessed res. bumped Lt [left] side of head . . . [neurological checks] started . . ." The physician responded, "No new orders. Max [maximum] fall precautions. Go back to Velcro belt?" A "Physical Restraint Assessment," dated 12/03/13, recommended the use of a self releasing lap belt due to a history of falls, short/long term memory problems, and an unsuccessful prior attempt at eliminating the lap belt. Current physician's orders stated, "Lap belt restraint to be in place when up in wheelchair."	F 323	each residents care plan will be reviewed to ensure the risk for falls has been established and individual interventions identified to prevent injuries from falls. A list of residents that utilize physical restraints have the potential to be affected in this area. All residents with a physical restraint will be reviewed to ensure they have been assessed, care planned, and monitored for proper application and use of the restraint to prevent falls. 3. A mandatory nursing inservice will be held on 2-19-2014 to educate the staff on the need to keep residents safe from falls and appropriate use and application of a lap belt and/or a person alarm associated with toileting to prevent falls. 4. An audit tool will be developed to monitor resident fall patterns, proper use and application of a lap belt or other type of restraint, and the appropriate use and management of personal alarms for behaviors associated with using the bathroom toilet. The audit will be completed by	

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F 323	Continued From page 18 Observation on 01/21/14 from 3:41 p.m. until 5:40 p.m. showed Resident #4 in her wheelchair in the TV area without a lap belt attached to her wheelchair. Staff were not always present in the TV area to supervise Resident #4. Observation showed Resident #4 attempted to stand from her wheelchair while unsupervised by staff. Observation on 01/22/14 at 3:01 p.m. showed Resident #4 unattended in the activities room without her lap belt fastened. The resident fidgeted in her wheelchair, made an attempt to stand, but then sat back down. At 3:15 p.m., an unidentified activities staff member brought various residents into the activities room for church. After attending church, staff took Resident #4 to the TV area. From 4:03 p.m. until 5:10 p.m., Resident #4 remained unattended in the TV area without her lap belt secured. Facility staff failed to secure the lap belt as per care plan. During an interview on 01/23/14 at 3:10 p.m., a supervisory nurse (#1) stated if staff are with the resident (such as during activities or meals) they can release the lap belt; otherwise, it is supposed to be fastened when Resident #4 is unsupervised. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included cerebrovascular disease, hemiplegia, and a history of falls. The current care plan stated, ". . . The resident is at risk for falls R/T impaired memory E/B Hx of falls . . . PERSONAL ALARM: tab alarm (to BR [bathroom] door and w/c) used to alert staff to resident's movement and to assist staff in monitoring movement. . . ." Nurses' notes stated the following:	F 323	the DNS or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the QA committee for further recommendations. 5. 2-27-2014	

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F 323	Continued From page 19 *11/30/13 at 5:30 p.m.: ". . . CNA [Certified Nursing Assistant] found resident on the floor of his bathroom. He made it to the BR but fell returning to his chair. . . ." *11/30/13 at 8:51 p.m.: ". . . Resident does not have any complaints of discomfort. . . . Resident remains impatient expecting staff to do things the second he wants them done . . ." Observations on 01/22/14 at 8:21 a.m., 9:27 a.m., and 10:50 a.m. showed Resident #7 seated in his wheelchair in his room. Observation showed the bathroom door frame with a tab alarm; however, staff failed to completely close the door and activate the tab alarm. Observation on 01/22/14 at 2:08 p.m. and 2:56 p.m. showed Resident #7 in bed and the bathroom door open without the tab alarm in place. At 2:56 p.m., a CNA (#4) assisted Resident #7 into his wheelchair but failed to close the bathroom door before leaving the room. At 4:05 p.m., a CNA (#4) assisted Resident #7 to the bathroom. Upon completion of toileting, the CNA closed the bathroom door and activated the tab alarm prior to leaving the room. Observation on 01/23/14 at 8:28 a.m., 9:31 a.m., and 10:05 a.m. showed Resident #7 seated in his wheelchair in his room. Observation showed staff failed to completely close the bathroom door and activate the tab alarm. During an interview on 01/23/14 at 3:10 p.m., a supervisory nurse (#2) agreed staff should not leave Resident #7 alone in his room without the tab alarm activated.	F 323		
F 325	483.25(i) MAINTAIN NUTRITION STATUS	F 325	F 325	2/27/14

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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 325 SS=G	Continued From page 20 UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, facility staff failed to implement appropriate interventions to restore/maintain adequate nutritional status for 3 of 3 sampled residents (Resident #5, #8, and #9) identified with weight loss. Failure to assess for underlying causative factors, implement interventions and/or evaluate the effectiveness of current interventions resulted in Resident #5, #8, and #9 experiencing severe weight loss. Findings include: Review of the facility policy titled "Monitoring Residents for Impaired Nutrition and Nutritional Risk" occurred on 01/23/14. This policy, dated August 2012, stated: "Procedure 1. Residents with impaired nutrition or nutritional risk may be identified by nursing, dietary and other members of the care plan team. 2. Nursing staff will notify the director of dietary	F 325	1.Resident # 5 individual needs have been addressed by updating the care plan to include the use of finger foods, fortified foods, a physician ordered house supplement, and the resident was moved to an assisted table. Resident # 8's individual needs have been addressed by separating her from her husband at meals as the husband wanted the wife to leave with him without providing her adequate time to eat her food. The Ensure plus pudding supplement is now provided between meals instead of with meals. Resident # 9 individual needs have been addressed by adding nutritional interventions such as fortified foods to her meals and care plan. 2. A list of residents that have experienced a significant weight loss of 5% in 30 days, 10% in 180 days, or insidious weight loss over time have the potential to be affected in this area. The list of residents will be reviewed to ensure the care plans address the nutrition problem with appropriate individualized nutritional interventions such as fortified foods.	2/27/14

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F 325	Continued From page 21 services (DDS) of new signs of nutrition risk. Written notification is placed in a location designated for the task within 24 hours . . . The DDS should be notified of: . . . Significant weight change, gain or loss, (3 pounds in one week, 5 percent [%] in one month, 7.5 percent in three months, 10 percent in six months). 3. The director of dietary services (DDS) . . . will identify residents with impaired nutrition or at nutritional risk such as: a. A low score on the mini-Nutritional Assessment . . . b. BMI [Body Mass Index] [less than] 19 or low weight for usual body weight. c. Meal or fluid intake less than 75 percent at most meals . . . e. Insidious weight loss/gain. 4. The DDS or designee will review resident weights monthly or more often to identify residents with significant weight loss . . . or insidious weight loss or gain. Insidious weight loss or gain refers to a gradual unintended, progressive weight loss or gain over time. . . ." - Review of Resident #8's medical record occurred on January 22-23, 2014. Diagnoses included dementia and irritable bowel syndrome (IBS). The quarterly Minimum Data Set (MDS), dated 12/07/13, identified Resident #8 required extensive assistance for eating. The dietary card identified a level 4 diet (regular diet) with fortified foods. The resident's current care plan stated, "Pot [potential] for alt [alteration] in nutrition R/T [related to] dementia . . . Level 4 regular diet. Review of Resident #8's weight record identified the following: * 09/18/13 - 125.2 pounds	F 325	System changes: 1. New menu's started on 2-17-2014 with fortified food extensions. 2. The DDS will run the Nutrition Risk Report weekly to identify the residents who may be at a nutritional risk and route to all members of the IDT. 3. A mandatory Dietary staff meeting was held on 2-18-2014 to educate the staff focusing on the need to accurately document meal intake and to monitor residents for decreased meal intake . A mandatory Nursing inservices will be held on 2-19-2014 to educate the staff on the procedure titled, "Monitoring Residents for Impaired Nutrition and Nutritional Risk. System change: Tray cards will be updated to include the need for fortified foods and	

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F 325	Continued From page 22 * 09/27/13 - 123 pounds * 10/14/13 - 121 pounds * 10/25/13 - 119 pounds - a 6.2 pound weight loss in five weeks (5%) * 11/28/13 - 115 pounds * 12/10/13 - 113 pounds - a severe weight loss of 12.2 pounds (9.7%) * 01/07/14 - 112 pounds * 01/21/14 - 112 pounds Review of Resident #8's dietary progress notes identified the following: * 11/14/13 - "Nutrition Risk: Wt [weight] 118# [pounds]. No longer gradual weight loss." * 12/19/13 - "Nutrition Risk: Gradual weight loss. Wt 113# which is down 5#/month (4.2%), and down 12.2#/admit [09/12/13] (9.7%) . . . Level 4 diet averagin [sic] 68%/79%/67% [breakfast, lunch, and dinner intake] of meals past 7 days. Will be discussed at Nutrition Risk. May need to add fortified foods and supplements." * 12/26/13 - "Weight 112# which is down 3#/month and down 13.2#/admit (10.5%). . . . Sign [significant] wt loss. Will start fortified foods. Likes sweets - no chocolate. Will monitor weight and may need to add supplements." * 01/09/14 - "Significant weight loss. Weight 112# which is down 1#/month, down 9#/3 months (7.6%) and down 13.2#/admit (10.5%) . . . Fortified foods and extra sweets were added the end of Dec. [December] Fax sent to Dr [doctor] for ensure pudding bid [twice a day]. Called daughter and left message. Will be discussed at Nutrition Risk." Observation on 01/22/14 from 5:45 to 6:20 p.m. showed of an unidentified Certified Nursing Assistant (CNA) encouraged Resident #8 to pick up her spoon and eat. The resident's meal	F 325	additional nutritional interventions as deemed necessary. All tray cards will be reviewed and updated to include all nutritional interventions per care plan such as fortified foods, small portions, etc. System Change: Staff will be trained to document fortified foods acceptance and intake or refusal by resident. System Change: Residents appearing on the Nutrition Risk Report will be discussed with the DNS and DDS during the IDT meeting to determine what if any interventions and /or assessments will be put in place. The resident's care plan will be updated to include interventions and/or assessments needed to be put in place and a measureable goal. If no intervention is put in place in the resident's care plan a progress note will be written to document the reason why it is not	

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F 325	Continued From page 23 included a bowl of chili, a bowl of mashed potatoes and gravy (fortified), a corn muffin, a glass of milk and juice, and an Ensure pudding. Observation showed Resident #8 took a couple small bites of the chili and mashed potatoes and picked at the corn muffin. The unidentified CNA failed to assist Resident #8 with her meal as per care plan. An interview with the Licensed Registered Dietician(LRD) (#8) occurred on the afternoon of 01/23/14. When asked about Resident #8's weight loss and the delay in dietary interventions, the LRD had no response. When asked about the Ensure pudding and why it's served with meals, the LRD (#8) stated nursing staff decide when to serve Resident #8 the pudding. The facility identified a 6.2 pound (5%) weight loss in five weeks and a severe weight loss of 12.2 pounds (9.7%) in 11 weeks. The facility failed to assess Resident #8's for underlying causative factors for the weight loss and failed to implement dietary interventions until 12/26/13. These failures resulted in Resident #8's continued weight loss. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included failure to thrive, dementia, and depression. The quarterly MDS, dated 12/21/13, identified the resident required set up help and supervision for eating. Resident #5's dietary card (likes, dislikes, diet level) identified a level 3 diet (regular diet with chopped or grounds meats) with fortified foods, likes toast, and dislikes bread and buns. Resident #5's current care plan related to	F 325	addressed on the care plan and if any further action needs to take place. All residents identified by the Nutritional Risk will be referred to the consultant Registered Dietitian. If the Dietitian is not present at the IDT meeting, the DDS will inform the Dietitian on the next visit to the facility. 4. An audit tool will be developed to make sure staff have identified the nutrition at risk problem on the care plan, have a measureable goal, appropriate nutritional interventions to prevent additional wt. loss, and to ensure that at risk residents are communicated with the registered dietician. An additional audit tool will be developed to review documentation of acceptance and the amount eaten or refused of residents with fortified foods. The audit will be completed by the DDS or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the QA committee for further recommendations. 5. 2-27-2014	

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Activities of Daily Living (ADLs) stated, "Eating: . . . . Resident is able to hold cup, feed self, eat finger foods independently." The care plan related to nutrition stated, "Pot for alt in nutrition R/T debility, dementia . . . Level 3 regular diet with toast only, no bread. Feeds self encourage to finish meal."

Review of Resident #5's weight record identified the following:
* 08/08/13 - 161.4 pounds
* 09/05/13 - 156 pounds - 5.4 pound weight loss in one month
* 10/30/13 - 155 pounds
* 11/27/13 - 149 pounds - 12.4 pound weight loss in two and a half months (7.7%)
* 01/01/14 - 146 pounds
* 01/08/14 - 143 pounds - 18.5 pound weight loss in 5 months (11.4%)
* 01/15/14 - 146 pounds

Review of Resident #5's dietary progress notes identified the following:
*12/26/13 - "Nutrition Quarterly Note: Level 3 diet averaging 54%/21%/67% [breakfast, lunch, and dinner intake] of meals . . . for 7 days. Chewing and swallowing intact with diet. Feeds self with supervision in dining room . . . Wt 149#, down 1.8#/month, down 6.8#/3months, and down 16.5#/6 months (9.9%) . . . UBW [usual body weight] for past year is usually in the 150s. Will monitor weight . . ."
*01/02/14 - Significant weight loss. Wt 146# which is down 2#/month, down 10#/3 months, and down 19.5#/6 months . . . Res [resident] was sign [significant] wt gain 6 months ago with 1 [plus] edema . . . Will start fortified foods." (The treatment records identified Resident #5 had 1 plus edema during the months of July and August

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2013 but the notes failed to identify a concern related to the edema).
* 01/09/14 - "Significant weight loss. Wt 143# which is down 5#/month, down 10#/3 months, and down 20.5#/6 months (12.5%) . . . Level 3 diet with fortified foods averaged 39%/7%/46% in the past 7 days which is less than usual. Has candy in room which family brings in. Called daughter to inform of weight loss and interventions. Fax send to Dr. for ensure pudding bid [twice a day] at AM & PM snacks . . ." (Review of the physician's orders and observations failed to show the addition of ensure pudding).

Observation of Resident #5 showed the following:
* 01/22/13 from 8:10 to 8:44 a.m. - Resident #5 seated in the dining room eating independently. The meal included a glass of milk, juice, and water, hot cocoa, a slice of toast, hot cereal, and a cheese omelette. When the resident left the dining room, observation showed he consumed all of the juice, water, hot cocoa, and toast. The omelette and hot cereal appeared untouched. Review of the intake log identified Resident #5 consumed 100% of his morning meal which contradicted the observation.
* 01/22/14 at 11:45 a.m. - Resident #5 consumed 100% of his juice, water, and hot cocoa before the CNA delivered his meal. His meal included mashed potatoes, Swiss steak, carrots, and mandarin oranges. He pointed to the meal and stated "throw it out". An unidentified staff member removed his meal and returned with a sandwich which Resident #5 pushed away and ate the mandarin oranges. The meal card stated the resident dislikes bread.
* 01/22/14 from 5:55 to 6:20 p.m. - Resident #5 received and refused his meal which included chili, mashed potatoes and gravy, a corn muffin,

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pudding. He consumed his juice and water. Observation showed no food substitutes offered.
* 01/23/14 from 8:10 to 8:50 a.m. - Resident #5 seated in the dining room eating independently. He poured milk onto his hot cereal, ate a few bites, and left the rest. Resident #5 consumed a slice of raisin toast and all of his juice, water, and hot cocoa. Review of the intake log identified the resident consumed 100% of his morning meal which contradicted with the observation.

An interview with the administrative dietary manager (#5) and the LRD (#8) occurred on the afternoon of 01/23/14. The dietary manager stated all residents who are on a fortified diet receive hot cereal for breakfast and mashed potatoes for lunch and supper. He also stated Resident #5 likes hotdogs and brats but will eat other meats if the CNAs cut it into bite size pieces. The LRD stated she initiated Ensure pudding (a nutritional supplement) for Resident #5 on 01/09/14. (The physician's orders failed to identify the addition of the Ensure pudding). Both staff members (#5 and #8) stated the facility does not keep a record of snack intake for residents with weight loss and they do not specifically record the amount of fortified foods consumed during a meal.

The facility failed to initiate dietary interventions until Resident #5 experienced a significant weight loss of 15.4 pound in five months (9.5%); failed to follow-up on why the Ensure pudding had not been initiated; failed to cut the resident's meat; substituted a sandwich for a noon meal when the resident "dislikes" bread; failed to offer a hotdog or brat; and failed to monitor/evaluate the resident fortified foods/supplement intake.

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F 325	Continued From page 27 - Review of Resident #9's record occurred on January 22-23, 2014. Medical diagnoses included anorexia, esophageal reflux, and gastritis. Resident #9's weight record identified the following: *08/15/13, 102.2 pounds *09/14/13, 102.4 pounds *10/18/13, 89 pounds - 13.1% change in one month *11/21/13, 88 pounds *12/19/13, 88 pounds *01/23/14, 87.6 pounds A progress note, dated 10/17/13, stated, "Nutrition Risk - Sign wt loss. Wt 89#, [down] 13.4 #/ month (13.1%) [down] 5.6 #/3 months, [down] 1.4 #/6 months. Meals averaged 79%/46%/68%. Rec [recommend] magic cup and fortified foods will monitor." A progress note, dated 12/19/14, stated "Nutr. [nutrition] Risk Low BMI [body mass index] of 16.5 Wt 90# which is up 2#/mo [month] down 12.4 #/3months and down 3#/6 mo. Level 2 NAS [no added sodium] diet [with] nectar liquids averaging 93%/46%/50% of meals past 7 days. Receives fortified foods and magic cup. Will be discussed at Nutr. Risk." Observation on 01/22/14 at 5:55 p.m. showed Resident #9 eating the evening meal of an eight ounce bowl of chili, one half cup butterscotch pudding, and eight ounces nectar thick cranberry juice. Review of Resident #9's dietary card identified "Fortified Food, Small Portions." Facility staff failed to serve Resident #9 fortified foods. The meal record identified Resident #9 consumed 25 percent of her meal on 01/22/14.	F 325		

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F 325	Continued From page 28 During an interview on 01/22/14 at 5:55 p.m., a cook (#9) identified the fortified food as mashed potatoes for all meals. During an interview on 01/23/14 at 10:20 a.m., the LRD (#8) stated dietary staff should provide the fortified foods, however they can add high calorie, high protein foods. During an interview on 01/23/14 at 11:45, an administrative dietary staff member (#5) stated nourishment or supplement intake is not documented separately from other meal items. Failure of the facility to assess Resident #5, #8, and #9's weight loss and implement dietary interventions in a timely manner, monitor the resident's intake of fortified foods and/or nutritional supplements, and provide the necessary assistance with meals resulted in these residents experiencing severe weight loss.	F 325		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and group interview, the facility failed to prepare food using methods to enhance flavor and texture for 1 of 1 meal (noon meal on	F364 ~~F-364~~	F 364 1. No specific resident was identified to be addressed in this area. 2. All resident that consume food by mouth have the potential to be affected in this area. This includes all residents except the resident that has a diet order for NPO. By educating and training our staff the food quality and texture will be improved.	2/27/14

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F 364	Continued From page 29 01/22/14) assessed with a test tray. Failure to ensure foods are prepared to promote palatability may impact food intake by residents. Findings include: Review of the facility's policy "Palatability of Food" occurred on 01/23/14. The policy, dated May 2004, stated, "Purpose: To ensure that dietary staff prepare and serve food that is palatable and attractive for residents. . . ." During a group interview, conducted on 01/21/14 at 4:00 p.m., three residents (Resident A, B, and C) voiced concerns regarding the facility serving non-tender meat. These residents specified pork chops and steaks as examples. On 01/22/14 at 11:50 a.m., after eating the noon meal, Resident A stated the meat (Swiss steak) had been "hard." - Observation during the noon meal occurred on 01/22/14 at 11:52 a.m. The menu identified Swiss steak or chicken as the main meal item. Resident #13 commented regarding the Swiss steak, "It's tough. See that?" The resident attempted to take a bite but was unable to bite off a piece, and unable to cut the Swiss steak. The resident stated, "It's tough. I can't even bite it." The meat appeared dry, and the surveyor asked Resident #13 if he would like a staff member to cut it up for him. The resident stated, "Well, maybe that will help." On 01/22/14 at 12:25 p.m, the survey team requested a test tray. The team of four surveyors determined the swiss steak (regular and mechanical soft texures) was tough and dry.	F 364	3. A mandatory nursing inservice will be held on 2-19-2014 to educate the staff on the procedure titled "Palatability of Food". The purpose is to serve resident meals that are palatable and attractive for residents. A mandatory dietary staff meeting will be held on 2-18-2014 to educate the staff on the new menu with fortified food extensions and why not to serve non palliative food. System change: SW will have food palatability as a standing agenda for three months at the resident council meeting for feedback on meal taste and if the meat is tender enough. 4. Department heads will be assigned to eat at least one meal per week for	

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F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of meal tray cards, and staff interview, the facility failed to provide fortified foods for 3 of 4 sampled residents (Resident #3, #9, and #11) identified as receiving fortified foods. Failure to ensure residents receive fortified foods as ordered has the potential for weight loss and nutritional risk. Findings include: Review of the facility policy titled "Fortified Foods" occurred on 01/23/14. This policy, dated 2012, stated "Purpose: To promote the use of fortified foods versus medical nutritional supplements when a resident's calorie and / or protein needs are increased or when a resident is experiencing weight loss. Definition: Fortified foods - Fortified foods are menu items and snacks that are enhanced through the addition of naturally concentrated ingredients while maintaining the identity of the item. E.g. [sic] increasing the calories and protein in milk, puddings, mashed potatoes and soups through the addition of nonfat dried milk and extra margarine . . . or increasing the calories and protein of a milkshake through the addition of nonfat dry milk, peanut butter and chocolate. . ." - Review of Resident #3's medical record	~~F 365~~ F365	three months at the facility. A survey on the food palatability and texture of the food will be provided for continuous quality feedback. The audit will be developed to monitor the look, taste, temp., and texture for food at meals. The audit summary will be completed by the DDS or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the QA committee for further recommendations. 5. 2-27-2014 F 365 Resident #3's individual needs have been met by obtaining an order for a Speech therapy consult on 2-14-2014 to assess and make a plan for why the resident is having difficulty with swallowing. Care plan updated. Resident #3 will remain on fortified foods and receive them as care planned.	2/27/14

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 _____	01/23/2014

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 365	Continued From page 31 occurred on all days of survey. Diagnoses included pressure ulcer of the heel and anemia. A dietary note dated 06/26/13, stated, ". . . Level 4 diet [with] fortified foods . . ." Resident #3's care plan identified the resident on a level 4 regular diet with fortified cereal at breakfast and potatoes at noon meal. Observation on 01/22/14 at the noon meal identified Resident #3 eating chicken, baked potato with sour cream, and carrots. Resident #3's tray card identified "fortified food." An interview during the meal with the dietary manager (#5) identified mashed potato as the fortified food item. During an interview on 01/22/14 at 12:15 p.m. dietary cooks (#6 and #7) identified Resident #3 does not receive fortified food. The cook (#7) looked at Resident #3's dietary tray card and stated he is not on fortified foods. This contraindicated what the tray card and care plan stated. During an interview at 12:35 p.m., a dietary manager (#5) identified Resident #3 received fortified foods due to weight loss and skin issues. This staff member confirmed the tray card said "fortified food." He further stated Resident #3 preferred a baked potato and staff should add extra butter and sour cream to the baked potato. The staff failed to add butter or extra sour cream to the baked potato he was served on 01/22/14 - Review of Resident #11's medical record occurred on 01/23/14. A dietary progress note, dated 01/09/14, stated, ". . . Receives fortified foods and 240 cc [cubic centimeters] supplement	F 365	Resident #9 individual needs have been met by adding nutritional interventions such as fortified foods to the care plan. Resident # 11's individual needs have been met by adding a potential for nutritional risk in the care plan due to recent difficulty with swallowing and his history of weight loss. He will continue on fortified foods. 2. All residents with a weight loss of 5% in 30 days, 10% in 180 days, and insidious weight loss over time have the potential to be affected in this area. A list of residents will be generated and each resident's care plan will be reviewed to ensure the nutrition at risk has been identified and if needed or recommended the residents will be care planned to receive fortified foods or physician ordered supplements.	

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F 365	Continued From page 32 bid [twice per day] . . ." Resident #11's current care plan identified "Level 4 [diet] - Ground Meats with Fortified Food . . ." Observation during the evening meal on 01/22/14 at 5:51 p.m. showed Resident #11's meal tray included chili, cornbread, butterscotch pudding, juice, coffee, water, and chocolate milk. The resident's tray card identified "fortified foods;" however, observation showed Resident #11 did not receive any fortified food items. - Review of Resident #9's record occurred on January 22-23, 2014. Medical diagnoses included anorexia, esophageal reflux, and gastritis. A progress note, dated 10/17/13, stated, ". . . Rec [recommend] magic cup and fortified foods will monitor." The weight record identified a 13.4 pound weight loss from 09/14/13 to 10/18/13. Observation on 01/22/14 at 5:55 p.m. showed Resident #9 eating. The meal included a bowl of chili, butterscotch pudding, and nectar thick cranberry juice. Review of Resident #9's dietary card identified "Fortified Food, Small Portions." Observation showed the resident did not receive fortified foods. During an interview on 01/22/14 at 5:55 p.m., the evening dietary cook (#9) identified the fortified food as mashed potatoes. During an interview on 01/23/14 at 10:20 a.m., a Licensed Registered Dietitian (#8) stated dietary staff should provide the fortified diet.	F 365	3. A mandatory nursing inservice will be held on 2-19-2014 to educate the nursing staff on the procedure titled "Fortified Foods" and to serve natural foods or to identify the foods that the resident likes to eat before starting supplements. A list of residents on fortified foods will be updated and shared with staff. Dietary staff will be educated on 2-18-2014 on how to serve the meal according to the tray card and the new menu. 4. An audit tool will be developed to monitor if the resident is receiving fortified foods according to the care plan. The audit will be completed by the DDS or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the QA committee for further recommendations. 5. 2-27-2014	