

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ORIGINAL

PRINTED: 01/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2014
NAME OF PROVIDER OR SUPPLIER CUSTER REGIONAL SENIOR CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1065 MONTGOMERY ST CUSTER, SD 57730	
(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 Surveyor: 32572 An extended/recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 12/15/14 through 12/18/14. Custer Regional Senior Care was found not in compliance with the following requirements: F166, F167, F241, F248, F252, F253, F280, F281, F309, F314, F323, F368, F441, F490, F493, and F520.	F 000	Addendums noted with an asterisk per 1/16/15 email from facility administrator. DW/SDDOH/ME	
F 166 SS=F	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on document review and interview, the provider failed to inform six of six randomly interviewed residents (unidentified per request) of any resolution to resident council grievances and/or individual resident or visitor concerns for the previous eleven months (1/2014 through 11/2014). Findings include: 1. Review of the following resident council meeting minutes revealed: *1/14/14: -Concerns: --"_____ doesn't feel the US flag is being cared for properly. Feels that it should be taken down in bad weather."	F 166		

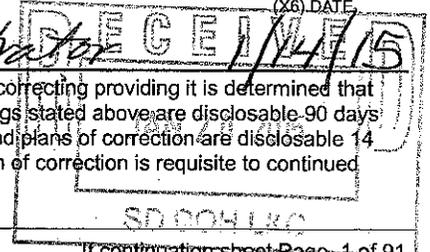
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

administrator



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 166	Continued From page 1 -New Business: --"4. Menus will change slightly. --12. Afternoon snack cart will stop since meals will be offered longer but HS [evening] snack will remain the same." *2/11/14: -Concerns: --"Residents unsure if the noise level has improved." -New Business: --"Bath schedules will change to accommodate those that would prefer to have their bath in the evening." *3/11/14: -Concerns: No updates noted. -New Business: --"3. There should be a snack out in the lobby. -- 4. _____ wants a snack at night. --10. _____ brought up the cold water situation. _____ said it was never fixed. --16. _____ says legs are cold. Hoping to get longer socks. --17. _____ asked about popcorn machine. --18. _____ informed residents about pop and candy machines and where they are located." *4/8/14: -Concerns: No updates noted. -New Business: --"3. Cold water due to all three tubs filling at once. --4. _____ would like to know why the kitchen says no more pickles? States he was told they wouldn't have them anymore. --18. _____ is asking that weekly bake club be added back to weekly activity calendar." *5/12/14: -Concerns: No updates noted. -New Business: --"4. One more change in dietary. No more	F 166	1. No immediate corrective action could be taken for affected residents given the evidence cited is from meetings in the past. 2. Social Service Designee (SSD) will discuss previously voiced concerns with residents and provide what information is available for resolving concerns. Residents and family members will be made aware of the changes made to the grievance process by 1/20/15. 3. All residents have potential of being affected. 4. The administrator and IDT revised the resident grievance policy & procedure on 1/10/15. All staff was educated by the Social Services Designee on the policy & procedure at an All-Staff inservice on 1/13/15. Those staff on vacation, sick leave or as-needed status will be inserviced by their supervisor prior to returning to work. 5. The SSD will report results of grievance resolutions at Quality of Life QI team meetings on an ongoing basis. 6. All residents will be given the option to choose a cable provider if they are not satisfied with the service provided by CRSC if they		

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F 166	Continued From page 2 bedtime snack cart going around. If residents would like an evening snack they are to go to the kitchen any time before 8:00 p.m. This is to improve on socializing and due to snacks being kept in rooms and getting old." *6/10/14: -Concerns: --"2. A. Bath water temperature is still going well. --2. C. Reassured residents to get their evening snack in the dining room before 20:00 [8:00 p.m.]." -New Business: --"4. _____ asked if we will be getting a popcorn maker again. _____ stated we will be ordering a new one soon." *7/8/14: -Concerns: No updates noted. -New Business: --"_____ brought up the topic that most staff don't knock, introduce themselves and let you know the purpose of their coming into your room _____ said that staff used to always do this but isn't done much anymore. Residents thought it would be nice if staff would knock, introduce themselves and inform resident of the purpose for their visit." --"_____ asked residents if they would like to have the local ombudsman come and talk about what she does and how she can be an advocate for their rights. All residents voting unanimous yes." *8/12/14: -Concerns: No updates noted. -New Business: --"3. _____ would like staff to not only knock on the doors, but also introduce themselves and let the residents know what they are doing when they come into his room. Everyone agreed that is what staff is supposed to be doing. --4. _____ son asked why the nursing home had such a strong odor lately. He stated it did not ever	F 166	choose to pay for that service by 1/20/2015. 7. In response to removal of the vending machines, Activities Department will provide a rolling cart from which residents can purchase requested snacks by 1/20/15. 8. Attendance of facility staff is by Resident Council invitation only. As the facilitator for Resident Council, SSD will inquire at each meeting if residents desire attendance by any other facility members for future meetings. 9. The water temperature identified in the tub rooms will be added to the daily walk through log already in place. <u>The three tub rooms will be checked on an ongoing basis by the maintenance staff. All findings will be reported to the Risk QI team.</u> <i>*Activities Director or designee will maintain a log of residents who opt for another cable service provider and report to quality of life QI team time 3 meetings. DW/SSDOH/MF</i>	1/20/15	

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F 166	<p>Continued From page 3</p> <p>used to smell so bad, but the last couple of months it has really had a bad smell.</p> <p>--8. ___ husband asked if we were short on housekeepers due to the cleanliness of the facility lately.</p> <p>--9. ___ asked about the conversion from cable TV to satellite TV. She went over the survey that the residents took regarding which channels they felt were most important. Asked if any of the residents had any other channels they would like to have that weren't on the list.</p> <p>--10. ___ wanted to know what her rights were as far as aides coming in and turning on her roommates TV to music early in the morning.</p> <p>--12. ___ asked if the residents like the food and food choices. ___ stated that she felt that if the menu changed, dietary needs to let the residents know. ___ stated that she would like to see just plain vegetables on the menu instead of always mixed."</p> <p>*9/9/14:</p> <p>-Concerns: No updates noted.</p> <p>-New Business:</p> <p>--"1. ___ wanted to know if there could be a certain time when residents had to turn off their TVs due to them being too loud at night and not being able to sleep. ___ stated she would look into who's TV might be too loud during the night.</p> <p>--2. ___ wanted to know why the vending machines were taken out of the building. ___ let the residents know it was taken out so that the residents could have healthier snacks provided for them.</p> <p>--3. ___, ___, ___ would like to go on a van ride soon. Recreational Therapy stated they can get a van ride planned soon.</p> <p>--4. ___ would like to go on a trip to the store to purchase candy. Recreational Therapy stated they can schedule a time to take her."</p>	F 166			

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F 166	Continued From page 4 *10/7/14: -Old Business: --1. "___ feels punished by the vending machines being taken out. Wants to be able to have chips and candy. --2. ___ wanted to know why van rides did not happen. Explained they did go on van rides. She wondered why she was not asked to go?" -New Business: --1. "___ (employee E) wants to start coming up with a solution to our issues brought up at resident council." --2. ___ feels residents have no say. She feels everything just keeps getting taken away. --3. ___ Kitchen does not have any of the kind of snacks that the machine had. Chips and candy bars. --4. ___ - new socks???? Cold all of the time." *11/4/14: -Concerns: --1. "___ Ideas to replace snack machine - selling snacks - fund raising. --2. Facility will provide temperature of comforting levels (TV volume). --3. All agree that employee E and ___ could send a letter and revisit having snack machine back or having a different option. --4. Employee E reported TV channels - chasing issue down - IT will be here soon to get TV channels back. Following up on it." -New Business: --1. "___ People [residents] come into room and they don't know what they are doing. Finds items misplaced. Feels everything has to be put away so others don't get into their belongings - Does not feel like a home environment. -- 2. ___ Other residents come in her room - it scares her."	F 166			

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F 166	<p>Continued From page 5</p> <p>Staff attendance at the above meetings included: *The current administrator and director of nursing had attended none of the eleven meetings. *The DM had attended one of the eleven meetings. *Three different social services coordinators or designees had attended the eleven meetings. *The housekeeping/laundry supervisor, activities coordinator, maintenance, or any other administrative staff were not noted in attendance for those eight months. *The local ombudsman had attended one of the eleven meetings. There was no note as to why she attended or if she gave any information.</p> <p>During resident group interview on 12/16/14 at 2:00 p.m. they voiced preference to not be identified individually and revealed: *They wanted the snack and pop machine back. There are several residents who missed having the machines. They were not allowed to make a choice about having it removed. *The provider had switched from cable to satellite TV. They still missed some of their favorite channels. There were several residents who watched a lot of TV. *The van activities had been discontinued. They felt they had missed out on a lot of town activities and nice days for rides. *They were not aware what the ombudsman did or who she was. They had seen her once, but had not seen her since. *Residents came in their rooms all the time and looked through their things. One resident had hit another. Nothing had been done. Had asked for banners across the doors and nothing was done. *The TVs were too noisy sometimes. *They were no longer offered or served night time snacks. They had to come to the dining room or</p>	F 166			

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F 166	<p>Continued From page 6</p> <p>nurses station to get a snack at night. *The resolution to their concerns and grievances by the council and other residents had been good. But they must continually ask to get something done now. *One resident had wanted to take a shower, but the shower was always cold. *About a third of the staff no longer knocked on the doors and just walked into their rooms. Some staff would knock but not tell them why they were in their rooms.</p> <p>Interview on 12/17/14 at 4:15 p.m. with the current activities designee E revealed she had been in the position about two weeks. She revealed and confirmed: *The DM had removed the offering of a night time snack. She was not aware a night time snack must be offered to all residents. *The DM had removed the snack and pop machines. She stated she had agreed with the DM they were not healthy snack options for the residents. She was not aware it was resident choice what they could and could not have for food choices. *The residents did not like the new TV channel provider. She had asked maintenance to look into the problem to see if they could get more channels. *They missed van activities and drives in the hills and around town. *They had discussed residents who had wandered into other residents' rooms, but nothing had been done yet. *They had discussed staff not knocking on doors or introducing themselves. She stated she had thought it was better. *She was not aware residents had a choice of a shower or whirlpool for bathing. She had thought</p>	F 166			

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F 166	<p>Continued From page 7</p> <p>the cold water problem had been fixed.</p> <p>*Concerns and grievances from resident council, family, or guests had not been reported as resolved or updated on the progression of the problem.</p> <p>*The local ombudsman came to one resident council meeting. But she did not come to the facility on a regular basis.</p> <p>*She thought she had found solutions to the other concerns brought forward by residents. But she had not kept any log or notes about the solutions.</p> <p>Interview on 12/18/14 at 2:00 p.m. with employee J revealed he had checked with the TV provider and the updates needed for the channels the residents preferred. He stated he had told employee E and the DON about three months ago an additional cost was needed for the upgrade and more channels. He had not heard back from them if they wanted to pay the extra costs for the residents to have more channels.</p> <p>Review of the residents' handbook revealed the following under Resident Council: "The purpose of the Resident Council is to provide a means for sharing concerns and ideas with other residents and staff members. As a resident at Custer Regional Senior Care, you are automatically a member of the council but participation is voluntary."</p> <p>Review of an untitled and undated policy revealed "F. Water temperatures are to be maintained per resident request or a standard of 105 degrees while no hotter than 125 degrees. Staff are to notify maintenance if water temperature is not able to be maintained and discontinue bathing."</p> <p>Review of an Exercise of Rights policy dated</p>	F 166		

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F 166	Continued From page 8 5/20/13 revealed: "Residents have freedom of choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, ..."	F 166			
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to ensure the resident council and residents were made aware of the most recent survey results, and where they were posted. Findings include: 1. Observation on 12/16/14 at 9:00 a.m. revealed the most recent survey results were posted near the bulletin board by the nurses station. During resident group interview on that same day at 2:00 p.m., they voiced preference to not be identified, and revealed they were not aware the results of the latest survey were posted in the facility. Nor were they aware where those results were posted.	F 167	1. No immediate corrective action could be taken for affected residents given no individual residents were identified. 2. The survey results remain posted in a conspicuous place at wheelchair accessible level with a large print sign stating "Survey Results" in a high traffic area. 3. Social Service Designee will inform residents at 1/20/15 Resident Council Meeting that the survey results are available to them and tell them where they are located. 4. Placement and availability of survey results will be monitored by SSD with the Resident Council mtg. and reported to the Quality of Life QI team meetings X 3 months.	1/20/15	

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F 167	Continued From page 9	F 167			
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on interview and resident's rights form review, the provider failed to maintain residents' rights according to three of three residents (8, 12, and 15) and six of six residents (identity [ID] kept confidential per residents' requests). Findings include:</p> <p>1. Interview on 12/17/14 at 4:40 p.m. with resident 12 revealed: *She did not use her call light most of the time. It did not help get staff to assist her any faster. *She would use it for her roommate. *She could not wait fifteen or more minutes for help to arrive, because she would "soil" herself. *She stated the CNAs would "snap" at her at times when she needed help. -She could not remember their names, but they still worked there.</p>	F 241	<p>1. Quality of Life---Dignity Policy was created collaboratively by the Administrator, IDT, and DON on 1/10/2015.</p> <p>2. Staff in all departments will be inserviced on 1/13/15 on the policy and procedure of providing care with dignity and respect by SSD or designee. Those staff on vacation, sick leave or as-needed status will be inserviced by their supervisor prior to returning to work.</p> <p>3. Social Service Designee or a designee will query residents at monthly Resident Council meetings for the next 6 months regarding being treated with dignity & respect.</p> <p>4. Staff will be educated at All Staff Meetings regarding providing care with dignity and respect ongoing.</p> <p>5. Administrative team will monitor on regular basis 3-5 times weekly during walking rounds. Findings will be shared by administrator at Quality of Life QI meeting X 3 months.</p>	1/20/15	

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F 241	Continued From page 10 Surveyor: 28057 2. Resident 8 no longer was able to watch her preferred television programs. That had been one of her primary activities she had enjoyed. Refer to F248, finding 1. 3. Resident 15 had not been offered activities of her choice or activities she had enjoyed. Refer to F248, finding 2. Surveyor: 20031 4. During resident group interview on 12/16/14 at 2:00 p.m. they voiced preference to not be identified individually and confirmed call lights "Were good when they were good. But when they were bad they were bad." They stated it was hard to sit and wait twenty minutes or more when you had to use the bathroom. They confirmed it happened more at night and in the early morning. Surveyor 28057 5. Review of the provider's admission packet had included a revised August 2011 Resident Rights form. That form stated the facility must treat the resident with dignity and respect with recognition of the resident's individuality.	F 241			
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248			

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F 248	Continued From page 11 This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on interview, record review, policy review, and job description review, the provider failed to offer an ongoing activity program to meet the residents' needs evidenced by: *One of one random resident (8) was unable to access the television programs she had previously enjoyed. *One of one random resident (15) had not been offered activities that were meaningful to her and/or that she had enjoyed. *One of one random resident (14) had limited attendance documented for activities for the month of November 2014. *None of the residents had been offered one-to-one activities as needed. Findings include: 1. Interview on 12/17/14 at 4:45 p.m. with resident 8 confirmed: *She was confined to a wheelchair. *Her primary activities she enjoyed had been watching television and reading books. *The provider had switched to a different company for television service. *Since that switch most of the television shows she had enjoyed were no longer available. *The new television service had limited the amount of activities that she enjoyed on a daily basis. Review of her 11/23/14 revised care plan revealed interventions related to activities included: *To engage her in simple, structured activities that avoided overly demanding tasks. *She preferred watching television; visits with	F 248	1. Administrator, IDT, and Activities Director collaboratively created Activity Provision and Evaluation Policy on 1/9/2015. 2. Resident #8 will be given the option of an alternative cable provider for her room at her cost if she is not satisfied with the television service provided by CRSC by 1/20/15. -All residents will be given the option to choose a cable provider if they are not satisfied with the service provided by CRSC if they choose to pay for that service by 1/20/15. 3. Residents #15: The evidence cited in the deficiency reads as follows, "resident had not been offered activities that were meaningful for her" and her "11/16/14 revised careplan revealed 'there had been no focus or goals related specifically to activities and there was no documentation indicating her specific needs or activity preferences'" In the process of the facility's development of this Plan of Correction, the 1/9/15 review of Resident #15's careplan reviewed on 11/13/2014 reveals: --a focus of "I come to the nursing home with an entire life full of experiences from my previous occupation, family, friends, and	

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F 248	<p>Continued From page 12</p> <p>family; playing computer games, cribbage with her son, bingo, and occasional group activities. *She chose to be in her room most of the time.</p> <p>2. Observation and interview on 12/18/14 at 1:15 p.m. with resident 15 revealed: *She was seated in the lobby facing the television. *Several other residents were seated around her facing the television. *Most of her time was spent watching television. *No other activity was offered very often. *She disliked bingo. *She would rather play volleyball or play cards including bridge.</p> <p>Review of her 11/16/14 revised care plan revealed: *There had been no focus or goals related specifically to activities. *A listed focus related to mental function had been an intervention for activities that accommodated her needs. *There was no documentation indicating her specific needs or activity preferences.</p> <p>Review of resident 15's activity participation documentation for November 2014 revealed: *She had been offered activities on twenty-three days out of thirty days. -She had refused activities on six of those days. *Seven days had no activities offered, attended, or refused by the resident. -The documentation had not listed what those activities had been.</p> <p>3. Review of resident 14's 11/17/14 revised care plan revealed: *She was dependent on staff for activities.</p>	F 248	<p>preferred recreation that affects my preferred activities” --a goal of “My personal preferences whenever possible during my cares daily” --and interventions of “I prefer listening to music, watching TV, socializing and participating in religious services. I am also a baseball fan and favorite team is the Rockies. I prefer to spend most of my day in my room engaged in self-directed activities but enjoy some group programs, music, trivia, and giant crossword”. Based on this resident’s Activity Assessment, this resident is not appropriate for one-on-one interventions. Activity Director or designee will assure the completion of Residents #8 and #15’s activity assessment to re-evaluate residents’ preferences and update careplan as needed and establish individualized and measurable programs of activities by 1/20/15. Activity Director or designee will assure completion of activity assessments for all remaining residents to re-evaluate residents’ preferences and update careplan as needed with quarterly assessments by 4/30/15.</p>		

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F 248	<p>Continued From page 13</p> <p>*Her activities were to have been compatible with her physical and mental abilities.</p> <p>*The activities were watching western shows on the television, spending time with family, observing people, and singing.</p> <p>*The goal was to attend activities daily.</p> <p>Review of resident 14's activity participation documentation revealed:</p> <p>*She had been offered activities on fourteen days out of thirty days in November 2014.</p> <p>*The other sixteen days of the month had no activities offered, attended, or refused by the resident.</p> <p>Review of the provider's August 2011 Resident Rights form revealed the provider must have a program of activities designed to meet the residents' needs and interests.</p> <p>Review of the provider's undated Activities Assistant Job Description revealed:</p> <p>*Job functions included providing an on-going activities program.</p> <p>*That program was to have been designed to meet the interests of each resident in accordance with the resident's comprehensive assessment.</p> <p>Surveyor: 20031</p> <p>4. During resident group interview on 12/16/14 at 2:00 p.m. they voiced preference to to be identified individually and confirmed "the activities isn't what it used to be months ago." They stated there was no variety anymore. They watched a lot of TV and movies. But the TV channels were now new, so they could not watch their old programs. "Week-ends are movies and church, movies and church." All six residents confirmed they had not seen any one-on-one activities with people who</p>	F 248	<p>All Staff will be educated at an inservice on 1/13/2015 on the policy and procedure for the provision of activities. Those staff on vacation, sick leave or as-needed status will be inserviced by their supervisor prior to returning to work.</p> <p><i>*The DON or designee will audit 10% of careplans to include activities assessment and report findings to Quality of Life at team times in months. DW/SDD/HMF</i></p>	1/20/15
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F 248	Continued From page 14 did not or could not attend group activities. "It's boring and everyone just wants to stay in their room as there is nothing to do." Review of a 5/20/13 Exercise of Rights policy revealed: "2. Residents will be encouraged to participate in activities of their choice, including participation in community activities. 3. Transportation to community activities may be arranged through the activity or social services departments."	F 248			
F 252 SS=C	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on observation, interview, and policy review, the provider failed to ensure the facility was free of preventable odors in four of four hallways (1, 2, 3, and 4). Findings include: 1. Random observation from 12/16/14 through 12/18/14 revealed: *Soiled linen and trash carts remained in each hallway daily. *Isolation soiled linen and trash carts were also kept in three of four hallways (1, 2, and 3). *Once those carts reached their maximum capacity the bagged linen was taken to the	F 252			

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F 252	<p>Continued From page 15 laundry room, and the bagged trash was taken outside. *The carts themselves were never removed from their original position in the hallways. *Automatic air fresheners and spray fresheners were noted throughout the facility, but the odor remained noticeable.</p> <p>Interview on 12/16/14 at 10:00 a.m. with the director of plant operations, maintenance supervisor, and housekeeping supervisor agreed: *There had been an odor problem in the facility for months. *They were aware the soiled linen and trash carts were stored in the hallways. *The housekeeping supervisor had been told by nursing to keep them in the hallways. *They were not aware soiled linen and trash containers must be stored in a ventilated room.</p> <p>Review of an undated Odor Control policy revealed: "4. Keep dirty linen/trash carts within reach during cares. 6. Dirty linen/trash carts are to be kept in the shower room or dirty utility room when you are not actively using them. 7. Trash is to be taken outside trash barrels before breakfast, lunch, supper, after rounds on night shifts, at shift change and PRN (as needed). 8. At shift change buckets are sprayed and cleaned with disinfectant."</p> <p>Review of a October 2007 procedure for Handling Contaminated Linen policy revealed: "1. All linen and clothing of an infected resident is placed in a dissolvable plastic bag in the resident's room. It will then be placed in another bag outside the door and marked contaminated.</p>	F 252	<p>The deficiency with the preventable odor will be rectified with a new protocol for the placement of linens, soiled linens and trash. CNA's will be provided with education on the frequent removal and the ability to identify the need to remove linens, and trash. This will be provided by an inservice with the Housekeeping Supervisor and will be a requirement for all CNA's by 1/15/2015. When linen carts are not actively being used they will be emptied to appropriate location and the empty carts placed in a ventilated room. Ventilated room locations are tub rooms on hall 1, 2, 3 or the alcove on Hall 1. This will be monitored by Housekeeping Supervisor or designee on a regular basis. Negative findings will be reported by the Housekeeping Supervisor at stand up meetings as needed. A trash receptacle will be placed in the biohazard room by housekeeping for the more frequent trash removal to take place. The Odor Control policy was updated on 1/10/2015 to address the necessary changes needed to meet the requirements for providing a safe, clean, comfortable home like setting and odor free environment.</p>	1/20/15

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F 252	Continued From page 16 2. The bag will then be taken to the laundry and placed in the container in the soiled linen room marked 'Isolation'. Review of an undated Corridor Obstacles policy revealed: "To keep corridors free from obstacles and provide a safe environment for all residents. A. All equipment will be stored in designated storage area while not in immediate use." Surveyor: 26632 2. Telephone interview on 12/16/14 at 1:17 p.m. with resident 12's family member revealed about two months ago there was a strong odor of urine when she entered the building. She had not been back since then, so she was not sure if it was still there or not.	F 252	* Housekeeping staff will be equipped with daily check sheets to monitor the carts and negative findings will be reported to infection control at each meeting times in months by the Housekeeping supervisor. DMS/BOH/MF	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to maintain: *Toilet base caulking in a cleanable, smooth condition for five of five resident rooms (209, 403, 405, 407, and 408). *Vinyl wheelchair armrests in a cleanable condition for seven of seven residents in rooms 102, 212A, 312, 403A, 405A, 405B, and 408B. *Hot water heater covers for two of two resident	F 253		

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F 253	<p>Continued From page 17</p> <p>rooms (304 and 407) in a proper and cleanable condition.</p> <p>*Walls for six of six areas (resident rooms 302, 305, 406, 408, and 410; and hall 2's storage room) in a durable and cleanable condition.</p> <p>*Cabinets or cabinet shelves for four of four resident use areas (north side of nurses station, beauty shop cabinets, bathing room shelves in hall three, and multi-purpose room cabinets) in a durable and cleanable condition.</p> <p>*The cleanliness of one of one resident's (7) recliner.</p> <p>Findings include:</p> <p>1. Random observation on 12/16/14 from 9:00 a.m. to 11:15 a.m. revealed:</p> <p>a. Caulking around the toilets in residents' rooms 209, 403, 405, 407, and 408 had separated from the base of the toilet, was missing in some areas, and/or appeared to be ribbons of frosting with embedded dirt and debris in them (photos 6 and 7).</p> <p>-Interview with the maintenance supervisor at the time of the observations confirmed those findings. He stated he had overseen the maintenance person who had done the caulking. But he had not checked all the rooms after he had finished.</p> <p>b. Vinyl wheelchair armrests for residents in rooms 102, 212A, 312, 403A, 405A, 405B, and 408B were cracked and missing vinyl pieces that revealed the padding beneath the vinyl (photos 2, 5, and 21).</p> <p>-Interview with the maintenance supervisor at the time of the observations confirmed those findings. He stated the maintenance department was in charge of fixing the wheelchairs if they could.</p> <p>-He stated the certified nursing assistants (CNA) who cleaned the wheelchairs and therapy were in charge of replacing armrests, seat cushions, or</p>	F 253	<p>A. The toilets identified will be re-caulked by 3/1/2015.</p> <p>A Preventative Maintenance (PM) schedule will be generated by the plant operations supervisor to have the toilets inspected on a monthly basis.</p> <p>Any and all findings will be reported to the Risk QI team by the plant operations supervisor on an ongoing basis.</p> <p>B. The wheelchairs identified will be replaced with new parts as needed. The wheelchair from room 102 has been pulled out of service. A PM will be generated by the plant operations supervisor to have the wheelchairs inspected on a monthly basis.</p> <p>Any and all findings will be reported to the Risk QI team by the plant operations supervisor on an ongoing basis.</p> <p>C. The heater covers identified will be replaced with new covers that have been ordered. A PM will be generated by the plant operations supervisor to have the heater covers inspected on a monthly basis for any damage.</p> <p>Any and all findings will be reported to the Risk QI team by the plant operations supervisor on an ongoing basis.</p>	

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F 253	<p>Continued From page 18</p> <p>foot pedals.</p> <p>c. Hot water heater covers in resident rooms 304 and 407 were either broken or dented and scratched (photo 8).</p> <p>-Interview with the maintenance supervisor at the time of the observations confirmed those findings. He stated the covers were in poor condition throughout the facility.</p> <p>-His department had been working on the heater covers for months now and were still not finished.</p> <p>d. Concrete block walls and gypsum board walls in residents' rooms 302, 305, 406, 408, 410, and in hall 2's storage room were cracked, damaged, or were missing patches of paint (photos 15, 16, and 17).</p> <p>-Interview with the maintenance supervisor at the time of the observations confirmed those findings. He stated he was aware the of the broken and damaged walls for resident rooms 406 and 408. A car had rammed into the building in that area and had damaged the walls. He stated the car damage had occurred last summer, and they were waiting for the outcome of the insurance.</p> <p>e. Cabinets or cabinet shelves for the north side of the nurses station, beauty shop, multi-purpose room, and bathing room shelves in hall three had missing laminate, gouges, scrapes, scratches, broken knobs, and chipped particle board (photos 1, 9, 10, and 29).</p> <p>-Interview with the maintenance supervisor at the time of the observations confirmed those findings. He stated he was aware the of the nurses station. It had been in that condition for over two years.</p> <p>-He stated he had been told to wait to repair the nurses station due to expense.</p> <p>-He was also aware the cabinets in the beauty shop and multi-purpose room were in need of repair or replacement. He was not aware the particle board shelves in the bathing room need</p>	F 253	<p>D. The walls identified in rooms 406 and 408 will be repaired by Jenniges Masonry. The rest of the rooms will be repaired by maintenance staff. A PM will be generated by the plant operations supervisor to have the room walls inspected on a monthly basis ongoing.</p> <p>Any and all findings will be reported to the Risk QI team meetings by the plant operations supervisor by an ongoing basis.</p> <p>E. The cabinets and shelves identified will be repaired by maintenance staff. A PM will be generated by the plant operations supervisor to have all cabinets and shelves inspected on a monthly basis ongoing.</p> <p>Any and all findings will be reported to the Risk QI team by the plant operations supervisor.</p> <p><i>* Negative findings of the monthly PM's will be reported to Risk QI times 6 months. DW/SDD/HMF</i></p>	1/20/15

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F 253	Continued From page 19 to be replaced. -He stated he relied on work orders for those needed repairs. f. Resident 7's recliner was matted with dirt and debris. A sweatshirt laid in the seat of the recliner. That sweatshirt was speckled with debris and matted with unknown dried and liquid debris (photo 18). -Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he was unaware of the condition of the chair. The uncleanliness should have been reported to the director of nursing by nursing staff. Surveyor: 32572 Review of the previous licensure surveys on 10/24/12 and 11/20/13 revealed F253 was cited for the following reasons: *Wooden surfaces had been uncleanable. *Caulking around the toilets had been loose and debris was present. *Chipped paint on the walls.	F 253			
F 280 SS=F	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280			

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F 280	<p>Continued From page 20</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057</p> <p>Surveyor: 26632</p> <p>A. Based on observation, record review, interview, and policy review, the provider failed to ensure care plans had been reviewed and revised for:</p> <ul style="list-style-type: none"> *Six of thirteen sampled residents (1, 2, 3, 8, 9, and 13) with pressure ulcers. *Two of two sampled residents (14 and 15) for the prevention of further falls. *Twelve of thirteen sampled residents (1, 2, 3, 4, 5, 6, 8, 9, 12, 13, 14, and 15) who had grab bars installed on their beds. <p>Findings include:</p> <p>1 a. Review of resident 3's skin integrity assessment records revealed she:</p> <ul style="list-style-type: none"> *Had been admitted on 12/10/14 with an open area to her right buttock that measured 1.8 centimeters (cm) in length by 0.8 cm in width by 0.1 cm in depth. She also had a blister noted to her left great (big) toe that measured 0.5 cm by 0.2 cm. *On 12/16/14 the open area on her right buttock measured 2.5 cm by 0.5 cm. with no depth noted. *A stage one pressure ulcer (intact skin that does 	F 280	<ol style="list-style-type: none"> 1. MDS Coordinator will educate the IDT on Comprehensive Care Plan Policy. 2. Residents 1,3, and 14 are no longer residents at the facility so cannot have careplans updated. 3. For all other potentially affected residents, careplans will be reviewed with their quarterly MDS assessment and as necessary and revised by the IDT by 4/30/15 4. IDT will receive electronic medical record (EMR) inservice to improve utilization and understanding of EMR functionality to assure that when the careplan is revised that it's reflected in the date on the careplan by 3/1/2015 <p>1b. Resident #13: Careplan revised 1/9/2014 to reflect history of wounds and current status of wound.</p> <p>Resident #2: The evidence was cited as "resident acquired pressure ulcer after admission which careplanning was not completed on". Upon IDT review on 1/9/2015 of Resident #2's careplan it was found that pressure ulcer was identified on 11/11/14 with a Pressure Ulcer Assessment record completed by staff RN and added to careplan on 11/12/14.</p> <p>Resident #8: careplan revised 1/9/2015 to reflect resolved stage II ulcer on bridge of nose and continued</p>	

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NAME OF PROVIDER OR SUPPLIER CUSTER REGIONAL SENIOR CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1065 MONTGOMERY ST CUSTER, SD 57730		
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F 280	<p>Continued From page 21</p> <p>not change color when pressed) to her right heel. It measured 2.0 cm by 3.5 cm. That was noted on 12/13/14 and was not present on admission. A foam border dressing was placed on this area. On 12/16/14 the measurements were 3.0 cm by 2.5 cm., and it was still noted as a stage one pressure ulcer.</p> <p>*An air mattress had been placed on her bed and foam boots were to be on her feet when in bed.</p> <p>Review of resident 3's interdisciplinary progress notes revealed:</p> <p>*On 12/10/14 at 7:18 p.m. an admission note "Skin issues are present. Has open area on right buttocks measuring 1.8 cm X (by) 0.8 cm. area cleansed and Meplix (protective foam) dressing applied. Has open blister on base of left great toe. Area cleansed and Band-Aid applied. Wound measured 1.4 cm X 0.4 cm.assisted to bed by two staff members."</p> <p>*On 12/11/14 at 3:47 a.m. "Resident resting. Moving self around in bed some."</p> <p>*On 12/11/14 at 3:33 p.m. "Resident up for meals in dining room."</p> <p>*On 12/16/14 at 7:30 a.m. "Orders for foam boots due to pressure area on right heel."</p> <p>*On 12/17/14 at 3:50 p.m. "Foam boots on with dressing changed to right inner heel."</p> <p>*On 12/18/14 at 3:02 a.m. "Foam boots on."</p> <p>Review of resident 3's initial care plan dated 12/12/14 (admission date 12/10/14) only addressed:</p> <p>*Her assistance with daily living self-care performance and interventions for bed mobility;</p> <p>*Transfers.</p> <p>*Dressing.</p> <p>*Eating.</p> <p>*Toilet use.</p>	F 280	<p>potential for future development.</p> <p>1d. Resident #9: Pressure relieving cushion now in wheelchair. IDT revised 1/9/2015 care plan to reflect current wound status and intervention of referral to therapy for evaluation of pressure relieving device in recliner where resident sleeps.</p> <p>2b. Resident #15: IDT will be educated on use by Information Technology of the Kardex in the electronic medical record by 3/1/15. Until that education the "CNA careplan" will continue to be used and retained.</p> <p>3a-h. All identified residents' beds with assist bars attached have been assessed by Therapy Department for appropriate use of assist bar as of 1/13/15.</p> <p>Remaining residents will be assessed by Therapy Department for appropriate use of assist bar by 1/20/15.</p> <p>After assessment is complete those residents deemed appropriate for continued use of assist bars will have careplan revised to reflect the bars use by 1/20/15.</p> <p>3i. New Comprehensive Care Plan policy in place by 1/20/15.</p> <p>B. No immediate corrective action could be taken for affected residents</p>	

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F 280	<p>Continued From page 22</p> <p>*Personal and oral hygiene. *Bathing and skin inspection.</p> <p>b. Review of resident 13's medical record revealed: *She had been admitted on 8/1/14. *She had no pressure ulcers when she had been admitted. *She developed a stage two pressure ulcer on 10/6/14 to her right hip that was healed on 10/18/14. *Her initial care plan developed on 8/11/14 had: *A focus area for the potential for pressure ulcer development. *A goal for her skin to remain intact. *Interventions included education to resident, family, and caregivers for causes of skin breakdown that included transfers, positioning, nutrition, and frequent repositioning. *The initial 8/11/14 care plan for pressure ulcers continued when updated on 9/13/14, 9/23/14, 10/2/14, and 11/9/14. *There was no care plan update to include the stage two pressure ulcer acquired on 10/6/14.</p> <p>Surveyor:28057</p> <p>c. Review of residents 1, 2, and 8's medical records revealed they had acquired pressure ulcers after they had been admitted to the facility. Care planning had not been completed to address those concerns. Refer to F314, findings 1, 2, 3, and 4.</p> <p>Surveyor: 32572</p> <p>d. Observation on 12/16/14 at 9:10 a.m. revealed an air mattress overlay on resident 9's bed. She did not have a pressure relieving cushion in her wheelchair.</p>	F 280	<p>given no individual residents were identified.</p> <p>Current practice of mailing letters to family members encouraging them to attend along with resident are sent to decision makers for the resident. If the resident is their own decision maker, he or she is provided a personal verbal invitation to attend by the Social Services Designee. A log indicating dates these invites were sent is kept. Moving forward, all residents will be invited via written invitation delivered to resident's room by SSD or designee. This will be included on the log that is currently kept and will be retained for one year.</p> <p><i>* The DDI or designee will audit 10% of care plans and report findings to Quality of Life QI team times 1st months. DM/CD/HH/MF</i></p> <p><i>* Log findings will be reported by SSD to Quality of Life QI times 3 months. DM/CD/HH/MF</i></p>	1/20/15

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F 280	<p>Continued From page 23</p> <p>Review of resident 9's medical record revealed she had a moisture related open area that would open and close at least monthly on her buttocks (bottom).</p> <p>Review of resident 9's current care plan revealed: *A focus area of "I have impaired skin integrity r/t [related to]diagnosis [dx] of diabetes, impaired mobility, congestive heart failure (ineffective pumping of the heart), incontinence." -That focus area had been dated 11/16/14. *The goal had been "My current wound will heal and I will have skin free of redness, blisters or discoloration by/through review date." -It had a revision date of 11/16/14 with a target date of 11/14/14 (which was prior to the revision date). *The interventions stated "Encourage frequent position changes to move pressure and rubbing against sore buttocks area. Encourage to sleep in bed instead of recliner, change from side to side."</p> <p>Interview on 12/16/14 at 9:10 a.m. with resident 9 indicated she had slept in her recliner and not in her bed.</p> <p>Interview on 12/18/14 at 12:50 p.m. with the administrator revealed she had not been aware resident 9 slept in her recliner. She was not aware resident 9 did not have a pressure relieving cushion in her wheelchair or recliner. She did understand the need for prevention measures to be in place for high risk residents. She confirmed the resident was at high risk for pressure ulcers.</p> <p>Surveyor: 28057 2 a. Review of resident 14's medical record revealed she had been admitted on 11/3/14. *Review of her 12/6/14 nurse's progress notes</p>	F 280			

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F 280	<p>Continued From page 24</p> <p>revealed she had fallen onto the mat next to her bed. Redness to her shoulder and right hip had been noted.</p> <p>Review of her 11/12/14 care plan revealed: *A focus that she had been at moderate risk for falls. *The risk had been related to incontinence (lack of control of urine and stool), gait/balance problems, confusion, and being unaware of safety needs. *Her goals had been she would not sustain a serious injury through 11/21/14 (already past). *Interventions had included: -Anticipating her needs. -Have her call light in reach. -Educate the resident, family, and care givers about safety reminders. -Follow the facility fall protocol. -Provide a safe environment. *There had been no documentation to support the care plan had been reviewed or revised since her fall on 12/6/14 for any additional interventions.</p> <p>Review of resident 14's Kardex (a quick reference for the individual needs and aspects of care for each resident) directions to the nursing assistants revealed it had not addressed her risk for falls or interventions to prevent a fall.</p> <p>b. Review of resident 15's medical record revealed she had been admitted on 9/30/11. Review of her nursing progress notes from 9/16/14 through 12/17/14 revealed she had fallen seven times.</p> <p>Her 11/5/14 Minimum Data Set assessment revealed she had one fall during the last quarter with an injury.</p>	F 280			

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F 280	<p>Continued From page 25</p> <p>Review of her revised 11/16/14 care plan revealed:</p> <p>*A focus area that she had been at high risk for falls.</p> <p>-The risk had been related to incontinence, gait/balance problems, vision/hearing problems, and psychoactive (affects brain function) medications.</p> <p>*Her goals had been she would not sustain a serious injury through 2/20/15. Interventions had included:</p> <p>-Anticipating her needs.</p> <p>-Have her call light in reach.</p> <p>-Educate the resident, family, and care givers about safety reminders.</p> <p>-Follow the facility fall protocol.</p> <p>-Provide a safe environment.</p> <p>*It had not been revised since her falls from 12/5/14 through 12/17/14 for any additional interventions.</p> <p>Review of resident 15's Kardex directions to the nursing assistants revealed it had not addressed her risk for falls or interventions to prevent a fall.</p> <p>3 a. Observation of residents 1, 2, 8, 14, and 15 revealed they had grab bars in place on their beds. Review of their medical records revealed the use of those grab bars had not been assessed or care planned to ensure they had been safe for those residents to use. Refer to F323, finding 6. i, j, k, l, and n.</p> <p>Surveyor: 26632</p> <p>Observation on 12/15/14 from 2:30 p.m. through 12/18/14 at 4:00 p.m. revealed residents 3, 5, 6, 12, and 13's beds had grab/positioning bars attached to them. All of the beds had a rail on both sides except for resident 12's bed that had</p>	F 280		

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F 280	<p>Continued From page 26</p> <p>only one on the side of the bed away from the wall.</p> <p>b. Random observation during the survey revealed resident 3 had a grab/positioning bar on both upper sides of her bed.</p> <p>Review of resident 3's complete medical record revealed she: *Had been admitted on 12/10/14. *Had no assessment for the use of the grab/positioning bar.</p> <p>Review of resident 3's initial care plan dated 12/12/14 revealed no mention of the use of grab/positioning bars.</p> <p>c. Random observation during the survey revealed resident 5 had a grab/positioning bar on both upper sides of her bed.</p> <p>Review of resident 5's complete medical record revealed she: *Had been admitted on 12/14/12. *Had no assessment for the use of the grab/positioning bar.</p> <p>Review of resident 5's care plan revealed no mention of the use of the grab/positioning bar.</p> <p>d. Random observation during the survey revealed resident 6 had a grab/positioning bar on both upper sides of her bed.</p> <p>Review of resident 6's complete medical record revealed she: *Had been admitted on 2/2/11. *Had no assessment for the use of the grab/positioning bar.</p>	F 280		

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F 280	<p>Continued From page 27</p> <p>Review of resident 6's care plan revealed no mention of the use the grab/positioning bar.</p> <p>e. Random observation during the survey revealed resident 12 had a grab/positioning bar on the outside of her bed.</p> <p>Review of resident 12's complete medical record revealed she: *Had been admitted on 8/12/13. *Had no assessment for the use of the grab/positioning bar.</p> <p>Review of resident 12's care plan revealed no mention of the use the grab/positioning bar.</p> <p>f. Random observation during the survey revealed resident 13 had a grab/positioning bar on both upper sides of her bed.</p> <p>Review of resident 13's complete medical record revealed she: *Had been admitted on 8/1/14. *Had no assessment for the use of the grab/positioning bar.</p> <p>Review of resident 13's care plan revealed no mention of the use the grab/positioning bar.</p> <p>Surveyor: 32572: g. Review of resident 4's care plan revealed: *A focus area of "I have an activities of daily living (ADL) self care performance deficit related to (r/t) limited mobility." The focus area had been initiated on 3/12/14. *The goal had been "I will maintain current level of function with bed mobility....with current interventions through the next review date. It had</p>	F 280			

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F 280	<p>Continued From page 28</p> <p>a target date of 12/05/14. (That date had passed.)</p> <p>*The interventions were "Encourage me to participate to the fullest extent possible with each interaction. Bed mobility: I require set up and supervision staff participation to reposition and turn in bed."</p> <p>*It did not indicate the use of the grab bar that had been on the bed.</p> <p>h. Review of resident 9's current care plan revealed:</p> <p>*A focus area of "I have an ADL self care performance deficit r/t limited mobility." The focus area had been initiated on 2/21/13.</p> <p>*The goal had been "I will improve current level of function in bed mobility....with current interventions through the next review date. It had a target date of 11/14/14. (That date had passed.)</p> <p>*The interventions were "Encourage me to participate to the fullest extent possible with each interaction. Bed mobility: I require extensive staff participation to reposition and turn in bed."</p> <p>*It did not indicate the use of the grab bars that had been on the bed.</p> <p>i. Review of the provider's undated Care Plans policy revealed "A comprehensive care plan shall be developed for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, [and] needs. Care plans are revised as changes in the resident's condition dictate. Reviews are made at least quarterly."</p> <p>Surveyor: 20031</p> <p>B. Based on interview and document review, the provider failed to ensure the resident council and all residents were personally invited to their care plan meetings. Findings include:</p>	F 280			

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F 280	Continued From page 29 1. During resident group interview on 12/16/14 at 2:00 p.m. they voiced preference to not be identified individually and revealed they were not personally invited to their care plan meetings. Interview on 12/17/14 at 4:15 p.m. with employee E revealed she was not aware resident council members nor the other residents had not been personally invited to their care plan meetings. She stated she was the social services designee and had just acquired the position about three months ago. She stated she thought she had let residents know about their care plan meetings in the last couple months. She stated she had not kept notes of her interaction with the residents regarding if the resident wanted to attend or had declined. Review of the undated Residents' Handbook revealed the following under Care Conference: "Residents and interested family members are encouraged to attend these meetings for their assistance, input and guidance." Review of a 5/20/13 Exercise of Rights policy revealed: "1. Our facility will encourage residents to participate in planning their daily care routines (ADLs)."	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281			

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F 281	<p>Continued From page 30 Surveyor: 32572 Based on observation, review of the manufacturer patient instruction, and interview, the provider failed to ensure the correct procedure had been used for the priming of an insulin pen by one of one registered nurse (RN) (Q) for one of one randomly observed resident (26). Findings include:</p> <p>1. Observation and interview on 12/16/14 at 7:55 a.m. of registered nurse (RN) Q revealed she was going to give resident 26 an insulin injection using an insulin pen. She had placed the needle on the pen and dialed in the correct number of units to be administered. She did not prime the needle with two units (specific unit of measurement) of insulin prior to dialing in the resident specific amount of insulin.</p> <p>Review of the manufacturer patient instructions revealed: *"The pen must be primed before each injection to make sure the Pen is ready to dose. Performing the priming step is important to confirm that insulin comes out when you push the injection button, and to remove air that may collect in the insulin cartridge during normal use." **"If you do not prime, you may get too much or too little insulin."</p> <p>Interview with the RN at the above time revealed the insulin pen was not to have been primed prior to administration.</p> <p>Interview on 12/18/14 at 1:40 p.m. with the director of nursing (DON) confirmed she expected the insulin pen to have been primed prior to administration of the resident specific insulin dose.</p>	F 281	<p>1. No corrective action could be taken for affected residents.</p> <p>2. An inservice provided by consultant pharmacist for all RN/LPN staff related to the appropriate administration of insulin will be provided on 1/15/2015.</p> <p>3. A policy addressing the proper administration of medications to include insulin, was collaboratively developed with IDT, consultant pharmacist, and Administrator.</p> <p><i>*The DON or designee will observe 2-3 nurses during insulin administration weekly for 3 months and report findings to Risk at times of meetings. DWISODD/HMF</i></p>	1/15/15

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F 281 F 309 SS=G	<p>Continued From page 31</p> <p>The provider did not have a policy on insulin pen administration and priming of the needle.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review and interview, the provider failed to ensure pain had been assessed and controlled for one of one sampled resident (3). Findings include:</p> <p>1. Review of resident 3's medical record revealed: *She had been admitted on 12/10/14 with diagnoses that included compression fractures (small breaks in the bones of the spine) in her back. *She had pain medications ordered that included: -Oxycodone (narcotic) 10 milligrams (mg) as needed for pain up to four times a day. -Oxycodone 5 mg as needed for pain up to four times a day. -Tramadol (non-narcotic) 100 mg as needed for pain up to four times a day. -Tramadol 50 mg as needed for pain up to four times a day.</p>	F 281 F 309	<p>1. No immediate corrective action could be taken for affected resident given the resident has passed.</p> <p>2. All residents have potential of being affected.</p> <p>3. Pain management policy was updated on 1/10/15.</p> <p>4. All RN/LPN and Medication Assessment staff will be educated regarding revised pain management policy on 1/15/2015.</p> <p>5. Will utilize Regional Health Hospice for end of life pain management education for nursing staff by 4/30/15.</p> <p>6. Will add pain component to Medication Administration Record (MAR) and Treatment Administration Record (TAR). Staff will assess for pain with each med pass and document on MAR/TAR by 1/20/2015.</p> <p>7. The updated Pain Management policy includes the following: The physician will be notified in the following instances:</p> <p>a. New pain that is severe or unusual for the resident.</p> <p>b. A change in severity and/or frequency of pain.</p>	

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F 309	<p>Continued From page 32</p> <p>-Lidoderm patch (topical pain medication) applied to lower back one time a day for pain and remove per schedule.</p> <p>*Flexible back brace to wear as tolerated when up.</p> <p>Review of resident 3's interdisciplinary progress notes and the December 2014 medication administration record (MAR) revealed she complained of pain and had received pain medications as follows:</p> <p>*On 12/10/14, her admission date, she had not received any pain medication.</p> <p>*On 12/11/14 at 2:11 a.m. she had rated her pain an 6 on a scale of 1 to 10 with 10 being the worst. She received oxycodone 5 mg at that time.</p> <p>*On 12/11/14 at 3:47 a.m. "Resident resting. Complaints of low back and foot pain. Pain med (medication) given."</p> <p>*On 12/11/14 at 7:56 a.m. she had rated her pain an 5. She received Tramadol 50 mg at that time. Five hours and forty-five 45 minutes since her previous pain medication.</p> <p>*On 12/11/14 at 4:42 p.m. she had rated her pain an 5. She received oxycodone 5 mg at that time. Three hours and fourteen minutes since her previous pain medication.</p> <p>*On 12/12/14 at 1:26 a.m. she had rated her pain an 10. She received oxycodone 5 mg at that time. Eight hours and forty-four minutes since her previous pain medication.</p> <p>*On 12/12/14 at 3:16 a.m. she had rated her pain an 9. She received tramadol 100 mg at that time. One hour and fifty minutes since her previous pain medication.</p> <p>*On 12/12/14 at 3:43 a.m. "Resident c/o (complains) and s/s [signs and symptoms] of pain upon movement. Oxycodone given at 1:30 a.m. with little relief. Resident given Tramadol</p>	F 309	<p>c. Pain unrelieved by current treatment.</p> <p>d. A change in level of consciousness or other symptoms related to over-dosage of pain medication.</p> <p>e. Anytime the nurse deems necessary or the resident/family requests.</p> <p><i>*The MDS coordinator will audit 10% of pain assessments monthly and report findings to a quality of life at team times in months. DWKDDO/HMF</i></p>	1/20/15	

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F 309	<p>Continued From page 33</p> <p>[tramadol)]100 mg at 3:15 a.m. and repositioned gently."</p> <p>*On 12/12/14 at 5:53 a.m. "Rechecked resident's pain level after Tramadol given. Was asked how was her pain now she stated she wasn't feeling any at present. Resident looks less tense than she has all shift that this nurse has seen."</p> <p>*On 12/12/14 at 10:31 a.m. she had rated her pain an 8. She received oxycodone 10 mg at that time. Seven hours and fifteen minutes since her previous pain medication.</p> <p>*On 12/12/14 at 4:37 p.m. "Daughter called this afternoon.....She also expressed concern for her mother's pain level and asks if it is possible for her to have scheduled pain control rather than PRN [as needed]. I will note this on Dr. _____ [name] patient sheet for next week and pass along request to weekend staff to stay up on pain control for her."</p> <p>*On 12/12/14 at 6:52 p.m. she had rated her pain an 8. She received oxycodone 10 mg at that time. Eight hours and twenty-one minutes since her previous pain medication.</p> <p>*On 12/12/14 at 10:12 p.m. she had rated her pain an 8. She received tramadol 100 mg at that time. Three hours and twenty minutes since her previous pain medication.</p> <p>*On 12/13/14 at 1:07 a.m. she had rated her pain an 10. She received oxycodone 10 mg at that time. Three hours and five minutes since her previous pain medication.</p> <p>*On 12/13/14 at 2:00 a.m. "Resident very restless, confused @ [at] times stating. "momma, momma." However had periods when she is able to answer questions appropriately. C/o back pain. Medicated with oxycodone/tramadol per MAR with some relief noted."</p> <p>*On 12/13/14 at 11:49 a.m. she had rated her pain an 8. She received tramadol 100 mg at that</p>	F 309		

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F 309	<p>Continued From page 34</p> <p>time. Ten hours and forty-two minutes since her previous pain medication.</p> <p>*On 12/13/14 at 5:56 p.m. "Resident very fearful with any movement. Cries out with any touching or movement. Was given Tramadol at noon and stated it helped and this pm she states she feels better."</p> <p>*On 12/14/15 at 12:27 a.m. she had rated her pain an 8. She received tramadol 100 mg at that time. Twelve hours and thirty-eight minutes since her previous pain medication.</p> <p>*On 12/14/14 at 3:05 a.m. "C/O pain with movement, pain medication given per MAR with results noted."</p> <p>*On 12/14/14 at 3:30 p.m. "Complains of back pain whenever she is moved."</p> <p>*On 12/14/15 at 8:21 p.m. she had rated her pain an 7. She received tramadol 100 mg at that time. Twenty hours and six minutes since her previous pain medication.</p> <p>*On 12/15/14 at 3:50 a.m. "C/O back pain medicated with PRN pain medication with relief noted."</p> <p>*On 12/15/14 at 1:21 p.m. she had rated her pain an 5. She received tramadol 50 mg at that time. Nine hours and thirty-one minutes since her previous pain medication.</p> <p>*On 12/16/14 at 7:30 a.m. "Resident was seen by Dr. _____ [name] on rounds for a follow up after recent admission to this facility & [and to evaluate her pain. Orders for scheduled pain meds [medication]."</p> <p>*She had not received pain medication on a regularly scheduled basis as her daughter had requested on 12/12/14.</p> <p>Review of resident 3's 12/12/14 initial care plan only addressed her assistance with daily living self-care performance and interventions for bed</p>	F 309		

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F 309	Continued From page 35 mobility, transfers, dressing, eating, toilet use, personal and oral hygiene, bathing, and skin inspection. Interview on 12/16/14 at 3:15 p.m. with the director of nursing revealed she: *Had not been aware resident 3's pain had not been managed. *She agreed resident 3's physician should have been contacted sooner than four days after a request to schedule her pain medication. Review of the provider's undated Admission Information revealed: *Pain was very common among the elderly, however, it was not a sign of normal aging. It might be a sign something was wrong. *Pain could cause loss of appetite, sleep disturbances, low energy, mood swings, and constipation. *Pain might also trigger preoccupation with physical symptoms, social isolation, inactivity, and depression.	F 309			
F 314 SS=I	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	F 314			

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F 314	<p>Continued From page 36</p> <p>by: Surveyor: 28057</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure seven of seven sampled residents (1, 2, 3, 5, 8, 9, and 13) had not acquired an avoidable pressure ulcer (area of skin breakdown, when something keeps rubbing or pressing against the skin) or skin tears after admission to the facility as evidenced by an ineffective care planning process and skin/wound preventative program. Findings include:</p> <ol style="list-style-type: none"> Review of resident 1's skin integrity (condition of the skin) assessment record from 8/22/14 through 12/15/14 revealed the following documented skin issues: <ul style="list-style-type: none"> *A skin tear to the right forearm on 8/22/14. *A skin tear to the right finger on 9/15/14. *A skin tear to the left wrist on 9/28/14. *A skin tear to the right ankle on 10/20/14. *A skin tear to the left hand on 11/12/14. *A pressure ulcer on the left hip on 12/13/14 that measured 4 centimeters (cm) long by 2 cm wide by 0.1 cm deep. <ul style="list-style-type: none"> -Was described as red with yellow areas. -No drainage and not open. -On a bony prominence (the hip). <p>*The above pressure ulcer was described on 12/15/14 as a reddened area with three small purple spots.</p> <ul style="list-style-type: none"> -No measurements had been included. -The skin remained intact. -An indication of a deep tissue injury (listed at the top of the provider's skin integrity assessment form used to document the pressure ulcer as listed above). <p>The physician's ordered treatments from 8/22/14</p>	F 314	<ol style="list-style-type: none"> No corrective action could be taken for all affected residents. Resident #2, skin was assessed on 12/28/14 and 1/4/15 and care plan revised on 1/10/15. Resident #5 care plan was revised on 1/10/15 to reflect skin tear was resolved. Resident #8, care plan was revised 1/10/15 to reflect PU is resolved. Resident #9 care plan was revised to reflect current wound status and interventions of skin barrier cream and referral to therapy for evaluation of pressure relieving device in recliner where resident sleeps. Resident #13, care plan revised 1/9/2015 to reflect history of wound and current status of wound. QAPI committee will designate a wound care, quality improvement team by 1/14/15. Wound care policy updated 1/12/15 to include skin assessments will be done upon admission and weekly thereafter. Turning and repositioning policy developed 1/10/15. All nursing staff will be educated on skin/wound care policy by 1/15/15 and new hires during initial orientation period. New weekly skin assessments tool will be implemented following staff education. Care plan will be revised utilizing the weekly skin assessment 	

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F 314	<p>Continued From page 37</p> <p>through 11/12/14 for the above skin tears had been:</p> <ul style="list-style-type: none"> *Cleanse with Saf-clens. *Apply Bacitracin ointment. *Cover with a Band-Aid or a Telfa pad and Tegaderm. *Change every third day or as needed until healed. <p>The physician's ordered treatment on 12/13/14 and listed on the treatment sheet for the above pressure ulcer had been:</p> <ul style="list-style-type: none"> *Clean with Saf-clens. *Cover with a DuoDerm dressing. *Check daily. *Change the dressing every three days and as needed until healed. <p>Observation with registered nurse (RN) Q on 12/16/14 at 10:30 a.m. during a dressing check for resident 1 revealed a DuoDerm dressing on the resident's left hip. It was intact. It was not changed as it had not been three days since the last dressing change as ordered. A purple coloration was noted through the dressing to the site covered by the dressing.</p> <p>Review of resident 1's last revised 7/24/14 care plan revealed:</p> <ul style="list-style-type: none"> *There had been no focus, goal, or interventions to address her frequent skin tears or to decrease or prevent more from occurring. *The focus related to pressure ulcers stated she had a potential for developing a pressure ulcer. *The potential had been related to her immobility and disease process (not identified). *Her goal had been to have intact skin free of redness, blisters, or discoloration until the next review date of 10/23/14. 	F 314	<p>tool. Nursing staff will be educated on proper application of assistive devices for the prevention of skin issues by 1/20/15. Nursing assistants will utilize revised 'CNA Care Plan' sheet for communication of resident care needs in lieu of Kardex. These will be retained in a file for one year.</p> <p><i>*DON or designee will audit skin assessments, turning and repositioning, and the application of assistive devices for prevention of skin issues on 10% of residents weekly and report audit findings to the infection control/wound care QI team times in months. DW/SD/DH/MF</i></p>	1/20/15

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F 314	<p>Continued From page 38</p> <p>*The target date of 10/23/14 was already past. *This goal had been initiated on 2/27/13. *The interventions listed had been: -Give medications as ordered. -Follow the provider's policies/procedures for the prevention/treatment of skin breakdown. -Use a Broda chair (creates redistribution of weight and pressure relieving) for positioning. -Inform her family of any new skin breakdown (the care plan stated she had no family involvement in another section). -Monitor her nutritional status. -Monitor laboratory and diagnostic results. *The pressure ulcer focus, goal, and interventions had not been changed and updated when she had first developed the pressure ulcer on her hip or as it worsened.</p> <p>Review of resident 1's 11/1/14 through 12/18/14 Turned and Repositioned documentation form revealed the resident had been repositioned only once every shift during that time frame. There had been no other documentation to support more frequent repositioning of the resident by the staff.</p> <p>Review of resident 1's Kardex directions to the nursing assistants revealed there had been only one direction for skin care/prevention of breakdown. It had stated to follow the policies/protocols for the prevention/treatment of skin breakdown.</p> <p>2. Review of resident 2's nurses' progress notes revealed: *On 10/27/14 she had been admitted with no open areas to her skin noted on that date. *On 11/3/14 at 3:54 p.m. she was noted as unable to move her right extremities.</p>	F 314		

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F 314	<p>Continued From page 39</p> <p>*She was able to move her left extremities.</p> <p>*On 11/11/14 at 8:03 a.m. the nursing assistant notified the nurse of a "bruise" to her right heel measuring 3.0 cm long by 4.0 cm wide by 0.0 cm deep.</p> <p>-The nurse identified it as an intact stage II pressure ulcer.</p> <p>-An air mattress was applied to the bed.</p> <p>-A foam boot was applied to that heel.</p> <p>Review of resident 2's skin integrity assessment record from 11/11/14 through 11/30/14 revealed:</p> <p>*She had a pressure ulcer on her right heel.</p> <p>*On 11/11/14 it had measured 3.0 cm long by 4.0 cm wide by 0.0 cm deep.</p> <p>-It was listed as a stage II and was described as intact and mushy.</p> <p>*Mushy was listed as an indication of a deep tissue injury (listed at the top of the skin integrity assessment form).</p> <p>*On 11/30/14 it had measured 5.0 cm long by 3.0 cm wide (had gotten larger) with no depth or stage documented.</p> <p>Review of the Heelift Glide Boot application and fitting guide revealed the heel was to be elevated by a foam block. The foam block ended before it met the heel causing it to be elevated and not in contact with any part of the boot to prevent pressure to the heel.</p> <p>Observation on 12/16/14 at 4:10 p.m. during a dressing change for resident 2 by licensed practical nurse (LPN) P revealed:</p> <p>*She had a foam boot on her right heel.</p> <p>*When it had been removed a pressure ulcer was revealed.</p> <p>*It was a dark purple area to the back of resident 2's right heel that had covered most of the back</p>	F 314			

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F 314	<p>Continued From page 40 of her heel.</p> <p>*There had been a second dark purple area above the first purple area on the heel.</p> <p>*Both were dry with peeling skin noted.</p> <p>*The boot was replaced after the dressing change had been completed.</p> <p>*When the foam boot was put back on the resident's foot it had not been applied correctly.</p> <p>*The thick foam pad had been placed directly against the dressed pressure ulcer causing pressure to the heel ulcer.</p> <p>Review of resident 2's 10/27/14 through 12/18/14 Turned and Repositioned documentation form revealed the resident had been repositioned only once every shift during that time frame.</p> <p>Review of resident 2's Kardex directions to the nursing assistants revealed there had been only one direction for skin care/prevention of breakdown. It had stated to follow the policies/protocols for the prevention/treatment of skin breakdown.</p> <p>Review of resident 2's 10/27/14 care plan revealed:</p> <p>*The focus related to pressure ulcers stated she had a potential for developing a pressure ulcer.</p> <p>*The potential had been related to her immobility, history of a stroke, recent falls, and incontinence (loss of bladder and bowel control).</p> <p>*Her goal had been to have intact skin free of redness, blisters, or discoloration until 2/13/14.</p> <p>*The interventions listed had been:</p> <ul style="list-style-type: none"> -Give medications as ordered. -Follow the provider's policies/procedures for the prevention/treatment of skin breakdown. -Inform her family of any new skin breakdown. -Monitor her nutritional status. 	F 314			

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F 314	<p>Continued From page 41</p> <p>-Report to the physician any changes in skin condition.</p> <p>*The pressure ulcer focus, goal, and interventions had not been changed and updated when she had first developed the pressure ulcer on her right heel or as it worsened.</p> <p>3. Observation from 12/15/14 through 12/17/14 revealed a Band-Aid in place on resident 8's nose. Her glasses had rested on the Band-Aid.</p> <p>Review of resident 8's nurses' progress notes revealed:</p> <p>*On 11/3/14 a stage II pressure ulcer was identified on her coccyx (bottom).</p> <p>*It had healed by 11/13/14 as documented.</p> <p>*On 12/9/14 a pressure ulcer was identified on the bridge of her nose.</p> <p>-It had been caused by her glasses and treatment was started that day.</p> <p>Review of resident 8's 10/1/14 through 12/18/14 Turned and Repositioned documentation form revealed she had been repositioned only once every shift during that time frame.</p> <p>Review of resident 8's Kardex directions to the nursing assistants revealed there had been only one direction for skin care/prevention of breakdown. It had stated to follow the policies/protocols for the prevention/treatment of skin breakdown.</p> <p>Review of resident 8's last revised 11/22/14 care plan revealed:</p> <p>*The focus related to pressure ulcers stated she had a potential for developing a pressure ulcer.</p> <p>*The potential had been related to her immobility and disease process (not identified).</p>	F 314		

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F 314	<p>Continued From page 42</p> <p>*Her goal had been to have intact skin free of redness, blisters, or discoloration until the next review date of 11/28/14.</p> <p>*The target date of 11/28/14 was already past.</p> <p>*That goal had been initiated on 1/15/13.</p> <p>*The interventions listed had been:</p> <ul style="list-style-type: none"> -Give medications as ordered. -Follow the provider's policies/procedures for the prevention/treatment of skin breakdown. -Inform her family of any new skin breakdown (the care plan stated she had no family involvement in another section). -Monitor her nutritional status. -Monitor laboratory and diagnostic results. -Report to the physician any changes in skin condition. <p>*The pressure ulcer focus, goal, and interventions had not been changed and updated when she had developed the pressure ulcer on her bottom or her nose.</p> <p>Surveyor: 26632</p> <p>4. Review of resident 3's skin integrity assessment records revealed she:</p> <ul style="list-style-type: none"> *Had been admitted with an open area to her right buttock that measured 1.8 centimeters (cm) in length by 0.8 cm in width by 0.1 cm in depth. She also had a blister noted to her left great (big) toe that measured 0.5 cm by 0.2 cm. *On 12/16/14 the open area on her right buttock measured 2.5 cm by 0.5 cm. with no depth noted. *A stage one pressure ulcer (intact skin with skin that does not change color when pressed) to her right heel. -It measured 2.0 cm by 3.5 cm. That was noted on 12/13/14 and was not present on admission. A foam border dressing was placed on that area. -On 12/16/14 the measurements were 3.0 cm by 2.5 cm. and still a stage one pressure ulcer. 	F 314			

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F 314	<p>Continued From page 43</p> <p>*An air mattress was on the bed and foam boots were to also be on the feet when in bed.</p> <p>Review of resident 3's interdisciplinary progress notes revealed:</p> <p>*On 12/10/14 at 7:18 p.m. an admission note stated "Skin issues are present. Has open area on right buttocks measuring 1.8 cm X (by) 0.8 cm. area cleansed and Meplix (protective foam) dressing applied. Has open blister on base of left great toe. Area cleansed and Band-Aid applied. Wound measured 1.4 cm X 0.4 cm. Taken to dining room by staff for lunch. States has no appetite. Did eat a few bites of her sandwich and all of her yogurt. Taken back to her room by staff. Assisted to bed by two staff members."</p> <p>*On 12/11/14 at 3:47 a.m. "Resident resting. Moving self around in bed some."</p> <p>*On 12/11/14 at 3:33 p.m. "Resident up for meals in dining room."</p> <p>*On 12/16/14 at 7:30 a.m. Orders for foam boots due to pressure area on right heal.</p> <p>*On 12/17/14 at 3:50 p.m. Foam boots on with dressing changed to right inner heel.</p> <p>*On 12/18/14 at 3:02 a.m. Foam boots on.</p> <p>Review of resident 3's initial care plan initiated on 12/12/14 only addressed her assistance with daily living self-care performance and interventions for bed mobility, transfers, dressing, eating, toilet use, personal and oral hygiene, bathing, and skin inspection. She had been admitted on 12/10/14.</p> <p>5. Observation and interview on 12/15/14 at 3:00 p.m. and again on 12/16/14 at 9:00 a.m. with resident 5 revealed she had two protective sleeves on her left arm and hand. When asked about those she stated:</p> <p>*She had open sores from always bumping her</p>	F 314			

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F 314	<p>Continued From page 44</p> <p>arms. *She wound just get one healed, and she would get another one. *No lift was used to assist her from her wheelchair to the bed or toilet. *Staff would just use her arms to help move her.</p> <p>Review of resident 5's care plan initiated on 1/27/14 with a revision on 10/4/14 revealed: *A focus area on restorative nursing services for active range of motion to lower extremities, walking, and transfers. *A goal to continue to receive those services. *Interventions were to provide those services in addition to notify the nurse: -Of any new skin tears. -To wear upper extremity skin sleeves at all times. *There was no further noted care plan for any other prevention of skin tears.</p> <p>6. Review of resident 13's medical record revealed: *She had been admitted on 8/1/14 with no pressure ulcers. *She developed a stage two pressure ulcer on 10/6/14 to her right hip that was healed on 10/18/14. *Her initial care plan developed on 8/11/14 had: -A focus area for the potential for pressure ulcer development. -A goal for her skin to remain intact. -Interventions that included education to resident, family, and caregivers for causes of skin breakdown that included transfers, positioning, nutrition, and frequent repositioning. *The initial 8/11/14 care plan for pressure ulcers continued when updated on 9/13/14, 9/23/14, 10/2/14, and 11/9/14.</p>	F 314		

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F 314	<p>Continued From page 45</p> <p>*There was no care plan update to include the stage two pressure ulcer acquired on 10/6/14.</p> <p>Surveyor: 32572</p> <p>7. Review of resident 9's progress notes in her medical record revealed a pressure ulcer that would open, close, and re-open on her buttocks. The 5/7/14, 8/1/14, and 10/29/14 Minimum Data Set (MDS) assessments revealed she had moisture associated skin issues. She had pressure relieving devices in her wheelchair and on her bed. The comprehensive current care plan indicated she had impaired skin integrity. That care plan did not reflect use of a barrier to prevent moisture associated skin issues.</p> <p>Observation and interview on 12/16/14 at 9:10 a.m. revealed resident 9 did not have a pressure relieving cushion in her wheelchair or recliner. She reported she slept in her recliner and did not sleep in her bed.</p> <p>Surveyor 26632</p> <p>8. Review of the provider's Performance Improvement (PI) Meeting minutes from January 2014 through November 2014 revealed:</p> <p>*January 2014; Residents with development of pressure ulcers within thirty days of admission. Initiate skin/wound care protocols for at risk residents that included heel lift boots, elbow pads, skin protectors, wheelchair cushions, air mattresses, dietary supplements, care plan updates, and a turning program initiation. There were no residents identified with pressure ulcers.</p> <p>*February 2014, A skin prevention system was in use that included a new documentation system for nursing, turning programs, and preventative skin care. There were seven pressure ulcers</p>	F 314		

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F 314	<p>Continued From page 46 noted.</p> <p>*March 2014, There were two pressure ulcers noted. There were no PI minutes on wounds.</p> <p>*April 2014, Concerns were being followed-up with physicians and families, specifically pressure ulcers. Treatment was documented in care plans. All nursing staff were educated on wound care, prevention, and administration of the Braden Scale. There were no pressure ulcers noted.</p> <p>*May 2014, Re-evaluate skin versus wound protocol. Update wound and skin assessments. There was one pressure ulcer noted.</p> <p>*June 2014, There were three pressure ulcers noted. There were no PI minutes on wounds.</p> <p>*July 2014, There were no pressure ulcers noted. There were no PI minutes on wounds.</p> <p>*August 2014, There were no pressure ulcers noted. There were no PI minutes on wounds.</p> <p>*September 2014, There was one pressure ulcer noted. There were no PI minutes on wounds.</p> <p>*October 2014, There were three pressure ulcers noted. There were no PI minutes on wounds.</p> <p>*November 2014, There was one pressure ulcer noted. Would use Regional Health outpatient wound care for complex wound treatment. Complex wound treatment to include special seating referral. Two residents were referred for non-healing wounds. Staff education for wound care.</p> <p>Surveyor: 28057 9. Interview on 12/18/14 at 10:05 a.m. with the Minimum Data Set assessment (MDS) registered nurse (RN) confirmed: *She had never seen a facility policy/protocol for the prevention/treatment of skin breakdown as listed on the Kardex (a quick reference for the individual needs and aspects of care for each resident) and care plans.</p>	F 314			

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F 314	<p>Continued From page 47</p> <ul style="list-style-type: none"> *Resident 1's care plan had not been updated to address the skin tears or pressure ulcer. *None of the residents' care plans were updated when care concerns occurred. -They were only updated during the quarterly MDS assessments. *Occasionally the director of nursing (DON) would update a care plan. *There was no procedure that addressed the day-to-day changes in care needs, or how they would be addressed. *The DON had a meeting with the licensed staff several weeks ago to address care plan changes. *She indicated she would meet with the licensed staff individually after that for more training. *The goal was to have the licensed staff change the care plans as needed. *That had not occurred yet. <p>Interview on 12/18/14 at 10:30 a.m. with the DON confirmed:</p> <ul style="list-style-type: none"> *Care plans were developed on a quarterly basis in conjunction with the MDS. *There was no process in place to adequately ensure the residents' care plans were updated between quarterly assessments. *She had been doing it when she could. *She had wanted the charge nurses to do the updates to the care plans. *There had been a Care Plan In-Service on 11/25/14 and 11/26/14. *The last Wound Care In-Service had been 3/18/14. *They had been in the process of developing a wound care team. *That need had been identified at the Quality Assurance Program Improvement meeting on 12/9/14. *She agreed residents 1, 2, and 8's care plans 	F 314			

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F 314	<p>Continued From page 48</p> <p>had not addressed their current needs related to pressure ulcers and skin concerns.</p> <p>*Agreed resident 2's foam boot had not been applied correctly to prevent further pressure to her pressure ulcer on her heel.</p> <p>*The Kiosk (stand to chart in computers) used by the nursing assistants had a Kardex button.</p> <p>*The Kardex was used to guide the nursing assistants in the care needed for the residents on an individual basis to include repositioning of the resident.</p> <p>*There was no option to direct staff to perform or document a scheduled turning/repositioning program for a resident if they had required one.</p> <p>*Repositioning was documented once a shift by the nursing assistants.</p> <p>*That was the default setting in the Kiosk charting for the nursing assistants.</p> <p>*When documented as done it indicated the resident's position had been changed at least once during their shift.</p> <p>Interview on 12/18/14 at 10:30 a.m. with nursing assistant S confirmed:</p> <p>*She had worked at the facility for about two months, since the end of October.</p> <p>*She had not been instructed in the use of the Kardex button or what it had been for.</p> <p>*She had not known how to access the residents' care plans.</p> <p>Review of the provider's undated Comprehensive Care Plans Policy revealed:</p> <p>*A comprehensive care plan was to have been developed and maintained for each resident.</p> <p>*It was to identify risks and problems.</p> <p>*Prevent decline in the resident's functional status.</p> <p>*The care plan was to be revised as changes in</p>	F 314		

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F 314	Continued From page 49 the resident's condition were needed. *It had not indicated who had been responsible for changes that occurred in-between the scheduled quarterly assessments. Review of the provider's undated Wound Care Policy revealed: *The type of wound was to be identified and a treatment plan developed. *Initiate specific interventions as appropriate. *Initiate a turning program. *One of the resources for development of the policy had listed the current DON.	F 314		
F 323 SS=1	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: Surveyor: 20031 Based on observation, record review, testing, policy review, and interview, the provider failed to ensure: *Four of four doors (front, maintenance/delivery, ambulance/staff, and multi-purpose room) routinely used by staff and visitors were alarmed at all times. *Two of two arms on the EZ lift (equipment used to transfer a resident from one place to another) in hall two were maintained to prevent possible	F 323		

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F 323	<p>Continued From page 50 skin tears and punctures. *One of one whirlpool room (in hall 3 secured unit), was locked. *Chemicals were secured in one of one whirlpool room (hall 3) and one of one resident room (102). *One of one live electrical wire was secured in one of three whirlpool rooms (hall 2) . *Thirteen of thirteen sampled residents (1, 2, 3, 4, 5, 6, 8, 9, 12, 13, 14, 15, and 16) reviewed had care plans, assessments, or education to nursing staff for grab or positioning bars on their beds. *Four of four (November, October, September, and August 2014) safety trend reports appropriately addressed the evidence and data in regards to the high numbers of falls and skin incidents for residents. Findings include:</p> <p>1. Observation on 12/16/14 from 9:00 a.m. to 11:15 a.m. revealed: a. Four routinely used entrance and exit doors (front, maintenance/delivery, ambulance/staff, and multi-purpose room) had no alarm when tested. Interview with the maintenance supervisor at the time of the testings and observations confirmed those findings. He stated "staff were to have the alarms on at all times unless they were in the direct line of sight of those doors." Further observation at that time revealed those four door alarms had been turned off at the nurses station. Two undated and unsigned notes had been posted next to the alarm panel that stated "Please keep alarms on" and "Please leave door alarms on" (photo 19).</p> <p>Review of a past event report dated 10/31/14 sent to the Department of Health from the provider revealed resident 33 had eloped from the facility twice in October 2014. The note from</p>	F 323	<p>a. Door Alarm Policy was reviewed and revised. All staff will be educated on the proper alarming for all doors on 1/15/2015. The door alarms are on a PM to be checked monthly and as needed and will be reported to the Risk QI team on an ongoing basis. b. The EZ lifts The EZ lift identified has been taken out of service. All lifts will be placed on monthly Plant Ops PM's with results reported to Risk QI team. c. The whirlpool doors will be placed on the Nurse rounds checklist for the charge nurses assigned to those halls with tub rooms. Any negative findings will be reported at stand up meeting for followup by administrative staff. d. The cabinet doors will be placed on a checklist for Housekeeping to assure they are locked with any negative findings reported at standup meeting. The odor spray bottle was removed in Room 102. Administrative team doing walking rounds 3-5 times a week will scan for any chemicals unlocked negative findings reported to stand up meeting for administrative followup. e. The electrical wires identified have</p>		

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F 323	<p>Continued From page 51</p> <p>that resident's latest elopement revealed she had entered the code to open the exit door. There was no notation the door had alarmed. She had been found approximately one block from the facility.</p> <p>Review of an undated policy titled Door Alarms revealed: **"Door alarms are utilized to improve the safety of our residents." **A. "Door alarms will be in use at all times for the doors at the ends of hall 1, 2, 4 and the west lobby. From sunset to 7 a.m. the door alarms in Sunrooms 1 and 2 will be active. Otherwise they will be in use on an as needed basis. Hall 4 door alarms are active from sunset until 7 a.m., during inclement weather, and additionally as needed. All other alarms are on from 10 p.m. until 5 a.m. and as needed. The floor nurse is responsible to turn on all alarms and to monitor the alarms during their shift."</p> <p>b. Both of the padded vinyl arms of the EZ lift in hall 2 were broken, had missing pieces, and had exposed metal (photos 3 and 4). That lift was used for residents. Interview with the maintenance supervisor revealed he was not aware of or maintained the EZ lifts. He relied on the CNAs or other staff to let him know about defective equipment. He agreed those arms were heavily damaged.</p> <p>c. Hall 3 secured unit's whirlpool room was unlocked. Interview with the maintenance supervisor and certified nursing assistant O confirmed that finding. She stated the whirlpool room door was to be locked at all times.</p>	F 323	<p>been repaired and no further action should be required.</p> <p>2a-n: All identified residents beds with assist bars attached have been assessed by Therapy Department for appropriate use of assist bar as of 1/13/15.</p> <p>Remaining residents will be assessed by Therapy Department for appropriate use of assist bar by 1/20/15.</p> <p>After assessment is complete those residents deemed appropriate for continued use of assist bars will have careplan revised to reflect the bars use by 1/20/15.</p> <p><i>*The DON or designee will audit nursing rounds checklists monthly and report negative findings to risk at team times w meetings. DW/SDDDH/MF</i></p> <p><i>*The housekeeping supervisor will report negative findings to risk at team times w meetings. DW/SDDDH/MF</i></p>	1/20/15

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F 323	<p>Continued From page 52</p> <p>d. The chemical storage cabinet inside hall 3 secured unit's unlocked whirlpool room was also unlocked (photo 29). Interview with the maintenance supervisor and certified nursing assistant O confirmed that finding. She stated the whirlpool room door and chemical cabinets were to be locked at all times.</p> <p>A chemical spray bottle to mask odors was stored on the back of a wheelchair in room 102 (photo 20). Interview with the housekeeping/laundry supervisor at the time of the observation confirmed that finding. She stated her staff kept all their chemicals and cleaners on their carts. The odor spray was used mostly by the nurses. She agreed all chemicals were to be kept locked and/or secured.</p> <p>e. Hall 2's whirlpool room had an open junction box and the electrical wire was not properly mounted or terminated. The end of the wire had been wound with black electrical tape (photo 11). There was also no evidence that wire was ground-fault protected. Interview with the maintenance supervisor and director of plant operations at the time of the observation confirmed that finding. They revealed they were not aware that wire had been left in that condition. Nor were they aware if that was a live wire. They stated they had thought someone would have told them about the wire when the laundry cart was moved to be restocked.</p> <p>Surveyor: 26632 2a. Random observation during the survey revealed resident 3 had a grab/positioning bar on both upper sides of her bed.</p> <p>Review of resident 3's complete medical record</p>	F 323	<p>*The electrical issue identified was a contractor issue. Plant ops will assure all contractor work is reviewed and inspected by facility plant ops upon completion of the contractor's work. Negative findings will be reported to Risk QI team by plant ops supervisor on an ongoing basis. DWISDDH/MF</p> <p>*The DON or designee will audit 10% of residents quarterly for completion of assist bar assessment and updated care plan times 12 months and report audit findings to Risk QI times 12 months. DWISDDH/MF</p>		

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F 323	<p>Continued From page 53 revealed she: *Had been admitted on 12/10/14. *Had no assessment for the use of the grab/positioning bar.</p> <p>Review of resident 3's 12/12/14 initial care plan revealed no mention of the use of grab/positioning bars.</p> <p>b. Random observation during the survey revealed resident 5 had a grab/positioning bar on both upper sides of her bed.</p> <p>Review of resident 5's complete medical record revealed she: *Had been admitted on 12/14/12. *Had no assessment for the use of the grab/positioning bar.</p> <p>Review of resident 5's 4/23/13 care plan revealed no mention of the use of the grab/positioning bar.</p> <p>c. Random observation during the survey revealed resident 6 had a grab/positioning bar on both upper sides of her bed.</p> <p>Review of resident 6's complete medical record revealed she: *Had been admitted on 2/2/11. *Had no assessment for the use of the grab/positioning bar.</p> <p>Review of resident 6's 10/29/14 care plan revealed no mention of the use the grab/positioning bar.</p> <p>d. Random observation during the survey revealed resident 12 had a grab/positioning bar on the outside of her bed.</p>	F 323			

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F 323	<p>Continued From page 54</p> <p>Review of resident 12's complete medical record revealed she: *Had been admitted on 8/12/13. *Had no assessment for the use of the grab/positioning bar.</p> <p>Review of resident 12's 8/12/13 care plan revealed no mention of the use the grab/positioning bar.</p> <p>e. Random observation during the survey revealed resident 13 had a grab/positioning bar on both upper sides of her bed.</p> <p>Review of resident 13's complete medical record revealed she: *Had been admitted on 8/1/14. *Had no assessment for the use of the grab/positioning bar.</p> <p>Review of resident 13's 9/1/14 care plan revealed no mention of the use the grab/positioning bar.</p> <p>Surveyor: 32572</p> <p>f. Observation on 12/17/14 at 10:30 a.m. revealed resident 4's bed had assist bars on the top third of the bed on the left side only.</p> <p>Review of his medical record revealed : *He had been admitted on 3/6/14. *No safety assessment had been completed for the assist bar. *He had a diagnosis of dementia.</p> <p>Review of the current care plan revealed no mention of the assist bar for bed mobility.</p>	F 323		

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F 323	<p>Continued From page 55</p> <p>g. Observation on 12/17/14 at 10:30 a.m. revealed resident 9's bed had assist bars on the top third of the bed on the left side only.</p> <p>Review of the medical record revealed: *She had been admitted on 5/9/12. *No safety assessment had been completed for the assist bar. *She had a diagnosis of dementia.</p> <p>Review of the current care plan revealed no mention of the assist bar for bed mobility.</p> <p>Interview on 12/16/14 at 9:10 a.m. revealed she slept in her recliner and did not sleep in her bed.</p> <p>h. Observation on 12/17/14 at 10:30 a.m. revealed resident 16's bed had assist bars on the top third of the bed on both sides.</p> <p>Review of the medical record revealed: *She had been admitted on 4/22/05. *No safety assessment had been completed for the assist bars. *She had a diagnosis of a stroke with some paralysis.</p> <p>Review of the current care plan revealed no mention of the assist bar for bed mobility.</p> <p>Surveyor: 28057</p> <p>i. Random observation during the survey revealed resident 1 had a grab/positioning bar on both upper sides of her bed.</p> <p>Review of resident 1's complete medical record revealed she: *Had been admitted on 7/10/12.</p>	F 323		

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F 323	<p>Continued From page 56</p> <p>*Had a diagnosis of dementia. *Had no assessment for the use of the grab/positioning bar.</p> <p>Review of resident 1's revised 7/24/14 care plan revealed no mention of the use of grab/positioning bars.</p> <p>j. Random observation during the survey revealed resident 2 had a grab/positioning bar on both upper sides of her bed.</p> <p>Review of resident 2's complete medical record revealed she: *Had been admitted on 10/27/14. *Had a diagnosis of dementia. *Had no assessment for the use of the grab/positioning bar.</p> <p>Review of resident 2's revised 11/17/14 care plan revealed no mention of the use the grab/positioning bar.</p> <p>k. Random observation during the survey revealed resident 8 had a grab/positioning bar on both upper sides of her bed.</p> <p>Review of resident 8's complete medical record revealed she: *Had been admitted on 12/31/12. *Had no assessment for the use of the grab/positioning bar.</p> <p>Review of resident 8's revised 11/24/14 care plan revealed no mention of the use of the grab/positioning bar.</p> <p>l. Random observation during the survey revealed resident 14 had a grab/positioning bar on both</p>	F 323		

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F 323	<p>Continued From page 57 upper sides of her bed.</p> <p>Review of resident 14's complete medical record revealed she: *Had been admitted on 11/13/14. *Had a diagnosis of dementia. *Had no assessment for the use of the grab/positioning bar.</p> <p>Review of resident 14's revised 11/17/14 care plan revealed no mention of the use the grab/positioning bar.</p> <p>m. Random observation during the survey revealed resident 15 had a grab/positioning bar on both upper sides of her bed.</p> <p>Review of resident 15's complete medical record revealed she: *Had been admitted on 9/30/11. *Had a diagnosis of dementia. *Had no assessment for the use of the grab/positioning bar.</p> <p>Review of resident 15's revised 11/16/14 care plan revealed no mention of the use the grab/positioning bar.</p> <p>n. Interview on 12/18/14 at 10:30 a.m. with the director of nursing confirmed the use of grab bars had not been assessed for safe use or care planned for the residents to use them. She agreed the grab bars should have been care planned for use by the above residents. She stated: "Had not even thought of doing that." She confirmed resident 1 "definitely should not have had a side rail on her bed as she would not have used it." She stated the grab bars should not have been put on the residents' beds without her</p>	F 323			

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F 323	<p>Continued From page 58</p> <p>direction. She could not explain why they were on the above residents' beds.</p> <p>Review of the provider's admission packet revealed a pamphlet "The aging process: Just the facts." Review of that pamphlet section on Falls and restraints revealed:</p> <ul style="list-style-type: none"> *Recent research had shown restraints might be a safety hazard. *Restraints were a form of medical treatment and needed to be monitored and continually evaluated. *Assistive devices could be used to assist the resident out of bed. *Bed rails could not be used to prevent a resident from leaving the bed as it would then be considered a restraint. *Injury could occur if the resident had slid between the rails or climbed over the rails to get out of bed. <p>In that same packet was a restraint policy. Review of the undated Restraint Policy revealed:</p> <ul style="list-style-type: none"> *In accordance with the State of South Dakota it was the responsibility of the provider to ensure the proper use of restraints. *A physician's order and a thorough assessment would be required for the use of any restraint. <p>Review of the provider's policy book and electronic on-line policies revealed no policy that addressed the specific use of grab bars or siderails as assistive devices or restraints.</p> <p>Surveyor: 20031</p> <p>19. Review of the past four month's November, October, September, and August 2014 safety trend reports revealed:</p> <ul style="list-style-type: none"> *Fourteen resident falls and twenty-five skin 	F 323		

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F 323	Continued From page 59 incidents in November. Recommendations had been "Increase in resident falls during transfers. *Twenty-one falls and twenty-nine skin incidents in October. Recommendations had been "Frequent fall assessments." *Thirty-six falls and sixteen skin incidents in September. Recommendations had been "Therapy evals (evaluations)". *Twenty-three falls and twenty skin incidents in August. Recommendations had been "Resident safety will be the topic highlighted at the next All-Staff meeting to include resident transfers." *Review of the past six months June through November 2014 of QAPI (Quality Assurance and Performance Improvement) monthly meeting minutes revealed no evidence or discussion in regards to the high numbers of falls and skin incidents. *Average census was about seventy residents per day.	F 323		
F 368 SS=C	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a	F 368		

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F 368	<p>Continued From page 60 nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on interview, the provider failed to ensure a bedtime snack had been offered to every resident every night. Findings include:</p> <p>1. During resident group interview on 12/16/14 at 2:00 p.m. they voiced preference to not be identified individually and confirmed evening (HS) snacks were not offered every night to every resident. They stated they would have to come to the dining room at a certain time every night if they wanted a snack. Surveyor: 28057 Interview on 12/18/14 at 1:45 p.m. with the certified dietary manager (CDM) confirmed: *The dietary department prepared a bucket of snacks for the nurses station every evening to be used for HS snacks for the residents. *The only residents who received a snack every evening had been those with a physician's order for an evening snack. *Snacks were not offered to the other residents, and they had to ask staff for an HS snack. *Residents incapable of asking for an HS snack had not received one unless their physician had ordered one for them at HS. *She had not known an HS snack was to have been offered every night to all residents to include those that could not request a snack.</p> <p>Review of the provider's undated admission packet revealed a special snack cart went from room-to-room every night at 7:20 p.m.</p>	F 368	<p>1. All staff was educated on the new policy titled "Frequency of Meals" on 1/13/14.</p> <p>a. An HS snack will be offered nightly to all residents. Snacks will be offered by Certified Nursing Assistant (CNA).</p> <p>b. Snacks required through MD or RD orders will be prepared by dietary, labeled and delivered to residents by CNA or nurse staff. These snacks will be documented.</p> <p>c. Meal/snack times will be posted in resident areas. Current practice continues assuring snack availability during a non-posted time.</p> <p><i>*The Dietary Director will audit documentation of offered HS snacks and documentation of MD or RD ordered snacks consumptions and refusals monthly. The dietary director will report audit findings to Quality of Life QI team times 3 meetings. DWJ/DDH/MF</i></p>	1/20/15

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F 368	Continued From page 61	F 368			
F 441 SS=L	<p>Surveyor: 20031 Interview on 12/18/14 at 4:00 p.m. with the CDM revealed she did not have a policy for HS snacks</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (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.</p> <p>(c) Linens</p>	F 441			

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F 441	<p>Continued From page 62</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Surveyor: 28057 Surveyor: 20031 Surveyor: 32572</p> <p>A. Based on observation, interview, record review, and policy review the provider failed to: *Identify necessity and implement appropriate contact isolation precautions. *Educate, train, and monitor all staff including housekeeping and laundry regarding the appropriate use of personal protective equipment, hand-washing, hand hygiene, and handling of soiled equipment, laundry, and trash. *Ensure all management and administration had been made aware of all the ill residents on hall 3. *Ensure timely notification about Reportable Diseases was made to the Office of Disease Prevention.</p> <p>NOTICE: Notice of immediate jeopardy (IJ) was given verbally on 12/16/14 at 5:30 p.m. to the administrator and the director of nursing (DON). The administrator was asked for an immediate plan of correction to ensure all residents with nausea/vomiting/diarrhea (N/V/D), residents with the signs and symptoms (s/s) of N/V/D, and those residents with the potential for N/V/D were</p>	F 441			

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F 441	<p>Continued From page 63 effectively managed.</p> <p>PLAN: On 12/16/14 at 7:24 p.m. the administrator and DON provided the surveyors with an immediate written plan of correction (POC) for that night. That POC dated 12/16/14 was accepted that same night by the surveyors and included:</p> <p>**Initiate contact precautions for Hall 3 residents and symptomatic residents in other halls. Precautions include: -Staff gowning and gloving when providing cares involving bodily fluids for the above identified residents. -Signage instructing appropriate isolation procedures are placed on doors where necessary. *Hall 3 is now isolated from other areas to include no visitors until results have been received from stool sample. *No other residents or staff other than those assigned specifically to Hall 3 will enter Hall 3. Staff leaving Hall 3 will doff (remove) the gown and gloves. *Families are currently being contacted concerning temporary visitation restriction. *Medical Director consulted and advised symptom management for resident hydration and treatment for febrile illness. Resident assess by physician this morning with stool sample ordered. *Resident that is symptomatic off Hall 3 is remaining in room with room trays delivered. *Biohazard waste are placed in red biohazard bag and disposed of per facility policy. *Contacted _____ [name] at State Health Department to report outbreak on 12/16/2014 at 1630 [4:30 p.m.] at _____ [telephone number]. *Staff coming on shift will be educated regarding</p>	F 441			

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F 441	<p>Continued From page 64 this plan.</p> <p>*Administrator and Director of Nursing have educated charge nurse who will then educate all staff coming on shift.</p> <p>*Director of Nursing will assure all of the above are accomplished."</p> <p>On 12/17/14 at 8:25 a.m. the administrator and DON provided the surveyors with the written Long Term Infection Control Action Plan POC. That POC included:</p> <p>***The DON will assure the provision of staff competencies to all facility staff regarding Custer Regional Senior Care (CRSC) infection control policies within 14 days. Infection control related education will occur monthly for all facility staff for one year. Nursing will be educated specifically on identifying and isolation issues that could become an infection control risk.</p> <p>*The DON will assure all facility staff are aware of and understands symptoms of infection to report to the charge nurse.</p> <p>*The DON will assure establishment and re-training of surveillance and trending of resident infection data and antibiotic use. The DON or designee will receive supplementary training on infection control monitoring.</p> <p>*The infection control program will be monitored by Quality Assurance Performance Improvement (QAPI) interdisciplinary committee through the infection control trend reports, audits, and action plans on an ongoing basis.</p> <p>*The infection control education will occur upon hire and annually for all facility staff beyond the e-learning modules currently provided.</p> <p>*An executive infection control team will be developed that will meet every two weeks for the next three months to review infection control data. This team will be comprised of the administrator,</p>	F 441			

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F 441	<p>Continued From page 65</p> <p>medical director, DON, resident care supervisor, activities director, infection control coordinator, and housekeeping supervisor. Nursing staff will be educated on the process of activating this team on an as needed basis.</p> <p>*An registered nurse (RN) will be designated as the Custer Regional campus-wide infection control coordinator.</p> <p>*Shift change communication of infection control issues will be reinforced by the DON on charge nurse report. Infection control issues will be discussed at the daily stand-up meetings on an ongoing basis. Stand-up meetings are attended by the DON, dietary manager, housekeeping supervisor, activities director, social services designee, resident care supervisor, physician nurse, two charge nurses, resident account representative, and the Minimum Data Set (MDS) coordinator.</p> <p>*The DON will be responsible for assuring the implementation and ongoing monitoring of this plan."</p> <p>Through continued survey on 12/17/14 at 2:13 p.m. revealed the surveyors confirmed removal of the immediate jeopardy situation.</p> <p>Findings include:</p> <p>1. Upon initial tour on 12/15/14 at 2:15 p.m. the DON reported there had been "a couple" of residents within the secured unit (hall 3) that had N/V/D last week, Thursday (12/11/14).</p> <p>2. Interview on 12/16/14 at 8:00 a.m. with certified nursing assistant (CNA) R stated eight of the thirteen residents in the secure unit had clear liquids for breakfast this a.m. due to N/V/D symptoms. She confirmed those residents came to the common dining area for breakfast. Staff</p>	F 441	<p>Short term plan for IJ.</p> <ol style="list-style-type: none"> 1. Initiate contact precautions for Hall 3 residents and symptomatic residents in other halls. Precautions include: staff gowning and gloving when providing cares involving bodily fluids for the above identified residents. Signage instructing appropriate isolation procedures are placed on doors where necessary. 2. Hall 3 is now isolated from other areas to include no visitors until results have been received from stool sample. 3. No other residents or staff other than those assigned specifically to Hall 3 will enter Hall 3. Staff leaving Hall will doff the gown and gloves. 4. Families are currently being contacted concerning temporary visitation restriction. 5. Medical Director consulted and advised symptom management for resident hydration and treatment for febrile illness. Resident assessed by physician this morning with stool sample ordered. 6. Resident that is symptomatic off of Hall 3 is remaining in room with room trays delivered. 7. Biohazard waste are placed in red biohazard bag and disposed of per facility policy. 		

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F 441	<p>Continued From page 66</p> <p>were "not able to keep them in their rooms and this is supposed to be homelike".</p> <p>3. Observation on 12/16/14 at 9:30 a.m. revealed resident 4 (in hall 3), had laid in an unoccupied bed in ____ (another room on hall 3). Resident 4 was one of the residents with N/V/D last week and continued to have clear liquids that a.m. Resident 4 was escorted back to his room by CNA R. Those bed linens of the unoccupied had not been removed after he had been escorted back to his room.</p> <p>4. Observation on 12/16/14 at 8:05 a.m. of CNA R in hall 3 revealed: *She had toileted resident 24. *She removed her gloves and did not wash her hands. *She touched numerous surfaces in the room. *She then applied new gloves to finish the task. *She then washed her hands.</p> <p>Surveyor: 20031</p> <p>5. Interview on 12/16/14 at 1:50 p.m. with housekeepers K and L revealed and confirmed they had been asked several questions from nursing assistant (NA) S about isolation. NA S told them she had not been told what to do when she came to work that morning, to only wear gloves. Housekeepers K and L confirmed what NA S had stated. They too had been told by the DON yesterday morning only gloves were needed for the isolation rooms and hall 3.</p> <p>Surveyor: 32572</p> <p>6. Interview on 12/16/14 at 3:15 p.m. with CNA V confirmed there were only three of thirteen residents on the secure unit who were not ill.</p>	F 441	<p>8. Contacted Vicki at State Health Department to report outbreak on 12/16/2014 at 1630 at 1-800-592-1861.</p> <p>9. Staff coming on shift will be educated regarding this plan.</p> <p>10. Administrator and DON have educated charge nurse who will then educate all staff coming on shift.</p> <p>11. DON will assure all of the above are accomplished.</p> <p>*All Staff will be educated on Infection Control procedures on 1/15/15. New hires will be educated on Infection Control Procedures during orientation. All staff will continue to be educated on Infection Control Procedures each month through January 2016. CDC Guidelines will be referenced. (HICPAC)</p> <p>**Nursing staff will be educated specifically on the identification of infectious process, the isolation precautions related to those infectious processes, and the communication of details to other staff involved in the care of individuals affected on 1/15/2015.</p>	12/16/14	

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F 441	<p>Continued From page 67</p> <p>Resident 19 had a high fever of 102.6 Fahrenheit (F) (normal of 98.6F), blood pressure 89/66 (normal of 120/50), and pulse of 102 (normal of 80). She stated the charge nurse told her that was normal for someone with a fever.</p> <p>When questioned about the precautions to take for the ill residents she stated she had been instructed to wash her hands.</p> <p>Surveyor: 26632</p> <p>7. Infection control program review and interview on 12/16/14 at 3:15 p.m. with the DON revealed:</p> <ul style="list-style-type: none"> *She was the designated person in charge of the infection control program. *She looked at the infections for the facility on a monthly basis. *She did not complete any trending of infections. *Not all infections had a culture taken. *The physicians had told her they looked at what antibiotic was currently used to treat a specific infection. They would then use that antibiotic. *She did not use McGeers recommendations for determining an infectious process or if antibiotics were necessary. *She did look at the cultures that had been completed. But she had not looked to see if the antibiotic used had been effective or if the organism was susceptible to the antibiotic. *She reported the infections to the quality performance improvement committee monthly. *No action was taken at those monthly meetings on infection rates. *She had not thought of reporting the current diarrhea and vomiting outbreak to the South Dakota Department of Health (SD DOH) as she had no actual diagnosis for those residents. *The reportable disease sheet was reviewed at the above time. The DON agreed the diarrheal 	F 441	<p>**All staff having contact with residents will be educated by DON or designee on what signs and symptoms must be reported immediately to the charge nurse for prompt followup on 1/15/2015.</p> <p>****Infection Control QI team (and Program) will be established through QAPI program. This team will utilize trend reports, audits, and action plans on an ongoing basis and function under the direction of QAPI. This team will meet every 2 weeks X 3 months, then at least quarterly thereafter. This team will consist of Administrator; Medical Director; Director of Nursing; Resident Care Supervisor; Activities Director; Housekeeping Supervisor; and any other staff the team deems beneficial.</p> <p>*****The DON or designee will assure infection issues are included on the 24 Hour Report.</p> <p>*****Infection control issues will be discussed daily Monday through Friday at Stand up meetings on an ongoing basis. Stand up meetings are attended by DON, Resident Care Coordinator, Dietary manager, MDS Coordinator, Resident Accounts</p>		

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F 441	<p>Continued From page 68 and vomiting outbreak should have been reported.</p> <p>- On 12/16/14 at 4:50 p.m. the DON reported the diarrhea and vomiting outbreak to the SD DOH.</p> <p>Surveyor: 28057</p> <p>8. Interview on 12/16/14 at 3:15 p.m. with CNA T revealed: *When she had reported for duty that day she had been told hall 3 had "a cold or some type of infection going around." *She had not been advised of any specific s/s to watch for as she cared for the residents.</p> <p>Interview on 12/16/14 at 3:20 p.m. with UAP U revealed the only precautions she had been told to interact with the residents who had been ill were " to wash or sanitize my hands after contact with them. "</p> <p>Surveyor: 32572</p> <p>9. Observation and interview on 12/16/14 at 3:20 p.m. revealed CNA T brought an unidentified resident into the secure unit to bathe her. She stated the other bath areas were busy and this one was open. She was aware the unit currently had illnesses.</p> <p>10. Interview on 12/16/14 at 4:15 p.m. with CNA W confirmed "everyone" on the secure unit had diarrhea and resident 19 had been running a high fever. She had been instructed to "foam in and foam out" (use of the hand sanitizer foam upon entrance and exit from the unit).</p> <p>11. Upon facility entrance on 12/17/14 at 7:40 a.m. surveyors were made aware through observation and interview seventeen of seventy-two residents were ill. A list of current</p>	F 441	<p>Representative, Charge Nurses, Housekeeping Supervisor and Activities Director.</p> <p>*Continued monitoring of infection control practices and skills will be ongoing by DON or designee by skills validations of 10% random sample of staff each month X 12 months. Skills to include but not limited to: Handwashing technique and proper use and handling PPE.</p> <p><i>*The random sample will include all departments in the facility. The DON or designee will monitor and report findings to infection control/wound care QI team times 12 months. DW/KDDH/ME</i></p>	1/20/15	

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F 441	<p>Continued From page 69</p> <p>residents was presented to the DON on that same day at 8:00 a.m. She confirmed five of the seventy-two residents were ill. She also confirmed one staff had called in sick with an illness related to NV/D.</p> <p>Interview again on that same day at 10:15 a.m. with the DON still confirmed five resident illnesses. The surveyor relayed to the DON there were seventeen ill residents. She was unaware or had not believed all of those residents were ill. She had instituted contact precautions to the entire secure unit. She had allowed ill residents to roam within the unit. She currently had set up two specific resident rooms within the secure unit for resident specific contact precautions. But she had allowed those two residents to roam the secure unit.</p> <p>Surveyor: 20031</p> <p>12. Interview on 12/17/14 at 9:35 a.m. with housekeepers K and L revealed they were not aware two unidentified residents on the hall 1 were ill.</p> <p>13. Care Fusion Surgical Clipper blades were stored in a drawer in hall 1's whirlpool room. Those blades had resident names written on the packages (photo 28). -Interview with CNA B at the time of the observation confirmed those findings. She stated the blades were not reused between different residents but reused for the same resident. She was not aware what the manufacturer's directions were for reuse of the blades. She had been told by the nurses to reuse those blades as they were expensive. -Review of the manufacturer's guidelines revealed the clippers themselves should have</p>	F 441		

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F 441	<p>Continued From page 70</p> <p>been disinfected between use. It gave no indication whether the blades could be disinfected and reused. It stated: "Disposable blade." Directions included: "1. Attach the blade: With glove on positions a new blade on top of the clipper head. 3. Remove the blade: Turn the clipper off, position the clipper blade facing downward over a sharps trash receptacle and use your thumb to push the blade forward along the blade frame."</p> <p>14. Interview on 12/16/14 at 10:30 a.m. with the maintenance supervisor, director of plant operations, and the housekeeping/laundry supervisor revealed they were unaware of the isolation precautions and infection control guidelines for hall three. The maintenance supervisor stated it was the first he had heard of it while on tour with the surveyor. They stated they had not been told residents had been ill and had shown signs and symptoms (s/s) of N/V/D in that hall.</p> <p>a. Continued interview on that same day at 2:30 p.m. with the housekeeping/laundry supervisor revealed:</p> <p>*She had heard who was ill through the "grapevine". There had been no meeting or announcement by the DON.</p> <p>*She had not been told to use any precautions with hall 3 or any other residents who showed s/s of the illness. Therefore she had not been able to tell her staff what precautions to use for their duties.</p> <p>*She stated she had found out at stand-up (meeting) on Monday morning (12/15/14) that a resident in hall 3 had become ill on Sunday (12/14/14). The DON had told the staff at stand-up she had been called at home about the ill resident. The DON stated other residents might</p>	F 441		

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F 441	<p>Continued From page 71 be also showing s/s of the illness. *She revealed there had been no stand-up today (12/16/14) for any updates.</p> <p>Surveyor: 28057 15. Observation on 12/18/14 at 8:55 a.m. revealed CNA N: *Had gloves on her hands. *Had not worn a gown or other protection over her uniform as she carried soiled linens from an isolation room (103) into the hallway. *Carried the soiled linens draped over her arms. They hung to the tops of her shoes and touched her uniform as she carried them into the hallway. *Stood in the hallway and asked other staff what she was to do with the soiled linens. *Placed the soiled linens in a closed container in the hallway at the direction of the other staff in the hallway.</p> <p>16 a. Interview on 12/18/14 at 9:05 a.m. with CNA N confirmed: *She had been instructed to wear a gown and gloves if she came in contact with any residents' body fluids. *She had been told a gown had not been necessary when she entered the isolation rooms unless she would come in contact with body fluids. *She had not realized she would be removing soiled linens when she had first entered the isolation room. *The linens she had carried out of room 103 had been wet with saliva from the resident. *She had not been instructed to bag the linen before removing it from the room.</p> <p>b. Observation on 12/18/14 at 9:30 a.m. revealed CNA N:</p>	F 441		

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F 441	<p>Continued From page 72</p> <ul style="list-style-type: none"> *Left isolation room 112. *Had not been wearing a gown. *Had removed her gloves and thrown them into a garbage receptacle outside of the room. *Did not wash or sanitize her hands, and she went to the other end of the hallway. *Conversed with an unidentified resident in a wheelchair. *The resident stated to her "I'm not sick yet." *CNA N had patted the resident on her shoulder with her unwashed hand as she visited with her. <p>17. Interview on 12/18/14 at 9:35 a.m. with nurse aide (NA) S revealed she asked this surveyor when she was to have worn a gown. She was not sure when it was required.</p> <p>Surveyor: 32572</p> <p>18. Interview on 12/18/14 at 12:50 p.m. with the administrator confirmed each resident needs to be considered infectious, not just the unit. Cross contamination needed to be closely monitored.</p> <p>Surveyor: 26632</p> <p>19. Review of the provider's undated Hand-washing/Hand Sanitizing policy revealed:</p> <ul style="list-style-type: none"> *Hand-washing was to be performed at the following times but was not limited to the following times: <ul style="list-style-type: none"> -Any time hands were visibly soiled. -Before and after each shift. -Before and after meals (both employee and resident). -Before and after contact with body fluids. -Before and after toilet use. *A hand sanitizer could be used between resident cares that did not involve body fluids. <p>20. Review of the provider's undated Infection</p>	F 441		

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F 441	<p>Continued From page 73</p> <p>Control Program policy revealed:</p> <ul style="list-style-type: none"> *The overall direction of the infection control program was the responsibility of the infection control committee and the medical director. *The day-to-day responsibility for the infection control program was the infection control nurse who reported to the DON. *The program would provide surveillance, education, and consultation to all departments. *Services provided included: surveillance; education for employees and residents; resources for policy development; advise all departments on infection related issues; assist physicians; residents/families; and employees should an outbreak occur; consultation with outside agencies such as the South Dakota Department of Health; and employee health programs. *Preliminary statistics would be examined monthly by the infection control nurse. *Statistics would be reported to the infection control committee monthly and to the PI committee quarterly. *Appropriate statistics would be reported to designated departments as necessary. *If monitoring activities identified problems the infection control nurse and committee would take appropriate action. <p>21. Review of the provider's June 2006 Nosocomial (infections acquired in the facility) Infections policy revealed:</p> <ul style="list-style-type: none"> *The infection control coordinator would divide statistics for infections into nosocomial and non-nosocomial and would report that information to the infection control committee or quality committee performing infection control oversight functions. *The committee would review the reports and 	F 441		

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F 441	<p>Continued From page 74</p> <p>identify trends, patterns, or problems that might reflect outbreaks.</p> <p>*The facility had established procedures and forms to perform and document surveillance.</p> <p>22. Review of the provider's revised June 2006 Reportable Diseases policy revealed should any resident or staff be suspected or diagnosed as having a reportable communicable/infectious disease the information should have been promptly reported to the state health department officials.</p> <p>23. Review of the provider's reviewed June 2006 Outbreak of Communicable Diseases policy revealed:</p> <p>*An outbreak of diarrhea was defined as three percent or more of the resident population within a seventy-two hour period.</p> <p>*Contacts were to be cultured as directed by the health department, medical director, and attending physicians.</p> <p>*Symptomatic residents and employees were to be considered potentially infected and were to be cultured and isolated as indicated.</p> <p>*The infection control coordinator and the DON would have been responsible for:</p> <ul style="list-style-type: none"> -Telephoning a report to the health department. -Restricting admissions to the facility as indicated or as authorized by the health department. -Submitting periodic progress reports to the health department. -Calling emergency meetings of the infection control committee. -Discontinuing group activities as indicated. -Limiting visitors if indicated. -Forwarding communicable disease report cards to the health department. -Maintaining a line listing of identified cases. 	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/18/2014
NAME OF PROVIDER OR SUPPLIER CUSTER REGIONAL SENIOR CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1065 MONTGOMERY ST CUSTER, SD 57730		
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F 441	<p>Continued From page 75</p> <ul style="list-style-type: none"> -Notifying the medical director and the attending physicians. -Assigning nursing personnel to the same resident group for the duration of the outbreak. *The nursing staff would have been responsible for: <ul style="list-style-type: none"> -Notifying the DON of symptomatic residents. -Initiating isolation barriers as directed or as necessary. -Confining symptomatic residents to their rooms as ordered. *The medical director was responsible for: <ul style="list-style-type: none"> -Working with the attending physicians and the health department to determine the need for laboratory specimens. -Overseeing the management of the outbreak. <p>B. Based on observation, interview, record review, and policy review, the provider failed to:</p> <ul style="list-style-type: none"> *Implement and maintain an effective infection control program. *Identify, track, and trend infections in a readiness manner to handle an outbreak among residents. Findings include: <ol style="list-style-type: none"> 1. Review of residents 4, 19, 22, 24, and 31's medical records revealed: <ul style="list-style-type: none"> --Resident 4 was diagnosed with conjunctivitis on 8/12/14. --Resident 24 was diagnosed with conjunctivitis on 8/18/14. --Resident 31 was diagnosed with conjunctivitis on 8/21/14. --Resident 19 was diagnosed with conjunctivitis on 8/21/14. --Resident 22 was diagnosed with conjunctivitis on 9/11/14. --All of the above residents had received orders for antibiotic eye drops. 	F 441		

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F 441	<p>Continued From page 76</p> <p>2. Continued interview on 12/16/14 at 3:15 p.m. with the DON revealed: *She was aware of only three of the five residents (19, 24, and 31) who had contracted conjunctivitis (infection in the lining of the eye) in August 2014. She had only reported those three residents names to the performance improvement (PI) committee. She had not known two other residents had conjunctivitis. -Those five residents were all on the 300 wing. -She had not completed any investigation of why those residents had contracted conjunctivitis or completed any education to staff. *The surveyor was able to determine the other two residents (4 and 22) who had conjunctivitis through record review and interview. The surveyor relayed that information to the DON.</p> <p>Surveyor: 26632</p> <p>3. Review of the provider's PI and safety trend report/recommendations meeting minutes revealed: *January 14, 2014 "No residents were on isolation. 1[one] UTI [urinary tract infection] and 1 URI [upper respiratory infection]. This also down from last month." That was December 2013 data. *January 2014 infection report with antibiotic use: Two wounds, two cellulitis (infection in skin), one URI, and three UTIs. Infection recommendations included the visitation policy was reviewed, infection rates were discussed, restrictions would continue for large groups. *February 11, 2014, "There were no deaths, no discharges or transfers and no cases of suspected influenza. And she (DON) was also pleased to report that the URI count was way down in January." *February 2014 infection report with antibiotic</p>	F 441			

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F 441	Continued From page 77 use: two UTIs and no URIs. *March 11, 2014, " _____ (DON) reported five residents were treated for UTIs and one received antibiotics for a wound." This was from the February 2014 data. *March 2014 infection report with antibiotic use: two URIs, one cellulitis, and one case of shingles [infectious disease related to chickenpox.] *April 9, 2014 " _____ [DON] reported there were no UTIs, two URIs and no residents were isolation in March." *April 2014 infection report with antibiotic use: one wound, seven UTIs, one URI, one cellulitis, one ear, and one dental." *May 15, 2014 " _____ [DON] reported there were seven UTIs, one URI and no residents were isolation in April." *May 2014 infection report with antibiotic use: Two UTIs. *June 18, 2014 " _____ [DON] reported there were no UTIs and two URIs in May." *June 2014 infection report with antibiotic use: Two URIs. *July 15, 2014 " _____ [DON] reported there were no UTIs and two URIs in June." *July 2014 infection report with antibiotic use: Three URIs and one wound. *August 27, 2014 " _____ [DON] presented the July safety reports. Of interest was the wound care and documentation of vital signs;" no mention of infections. *August 2014 infection report with antibiotic use: five UTIs and three conjunctivitis. Five residents treated with only three residents reported: *September 9, 2014 " _____ [DON] presented August safety reports. Of interest was C-Diff (clostridium difficile-infection in the lining of the intestine) isolation report to state." *September 2014 infection report with antibiotic	F 441			

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F 441	<p>Continued From page 78</p> <p>use: one dermatitis (infection of the skin), two wounds, and one UTI.</p> <p>*No October 2014 or November 2014 minutes.</p> <p>*October 2014 infection report with antibiotic use: one URI and six UTIs.</p> <p>*November 2014 infection report with antibiotic use: one URI, two UTIs, one stool (bowel movement), and one wound.</p> <p>4. Review of the provider's 2014 PI audits for infection control topics with a achievement threshold of 90% for all audits included:</p> <p>*Hand-washing for nursing with an average of 93.8% (percent).</p> <p>*Hand-washing for activities with an average of 64%.</p> <p>*Glove use for dietary with an average of 93.9%.</p> <p>*Hand-washing for dietary with an average of 98.2%.</p> <p>*Catheter care for nursing with an average of 89.9%.</p> <p>*Glove use for nursing with an average of 82.2%.</p> <p>*Whirlpool cleaning for nursing with an average 92.2%.</p> <p>*Hand-washing for nursing by the staff development nurse was an average of 86.3%.</p> <p>*Hand-washing for housekeeping with an average of 73.3%.</p> <p>There were no indications in the PI minutes of any special focus applied to those reviewed areas that had not met the threshold of 90%.</p> <p>5. Review of the provider's reviewed June 2006 Infection Control Coordinator Policy revealed the infection control coordinator should:</p> <p>*Coordinate the development and monitoring of the facility's established infection control policies and procedures.</p>	F 441		

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F 441	<p>Continued From page 79</p> <p>*Be aware of changes in infection control guidelines and regulations.</p> <p>*Collect and report statistics related to the facility's infections trends, patterns, and issues.</p> <p>Surveyor: 20031</p> <p>C. Based on observation, interview, manufacturer 's guideline review, and policy review, the provider failed to ensure:</p> <p>*Appropriate cleaning of the multiple resident use glucose meters.</p> <p>Findings include:</p> <p>*The clean linen cart in one of three bathing rooms (hall one) was clean and cleanable.</p> <p>*Four of four electric razors in two of three bathing rooms (hall one and three) were cleaned and disinfected.</p> <p>*Two of two plastic bins in two of three bathing rooms (hall one and three) that held resident hygiene items were clean.</p> <p>*Whirlpool mats for three of three bathing rooms (halls one, two, and three) were cleaned and disinfected between resident use.</p> <p>*Personal staff drinks were not in one of three (hall 2) resident bathing rooms.</p> <p>*A supplemental drink for residents was kept properly protected on one of three medication carts (hall 2 and 3).</p> <p>*CareFusion Surgical Clipper blades were not re-used on residents.</p> <p>*All management and administration had been made aware of five of five ill residents on hall 3.</p> <p>Findings include:</p> <p>1. Random observation on 12/16/14 from 9:00 a.m. to 11:15 a.m. revealed:</p> <p>a. The clean linen cart in hall one had rusted shelves (photo 23). The cover for that cart had a smeared gelatinous substance that covered the</p>	F 441		

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F 441	<p>Continued From page 80</p> <p>inside of the cover (photos 25 and 26). -Interview with the housekeeping/laundry supervisor at the time of the observation confirmed those findings. She stated that was not one of her laundry carts, and it belonged to nursing to transport clean linen. It would have been up to nursing staff to report the uncleanliness of the cart to the DON.</p> <p>b. Four electric razors in the bathing rooms of hall one and three held beard and skin debris inside the cover of the blades (photo 22). -Interview with CNA O and A at the time of the observations confirmed those findings. They stated the razors were to be cleaned and disinfected between each resident and not left dirty.</p> <p>c. The plastic bin with nail clippers in the bathing room of hall three was dirty and had nail clippings (photo 27). -Interview with CNA O at the time of the observation confirmed that finding. She stated the clippers were to be cleaned and disinfected between each resident. She also stated the storage bin was to be kept clean daily.</p> <p>d. The bottom of a plastic bin in hall one's whirlpool room held resident hygiene items such as mouth swabs and toothpaste. The bottom was layered with an unknown gelatinous pink substance (photo 13). -Interview with CNA B at the time of the observation confirmed that finding. She stated the plastic tubs were to be kept clean by nursing staff.</p> <p>e. Three of three whirlpool mats were not cleaned and disinfected between each resident's bath.</p>	F 441		

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F 441	<p>Continued From page 81</p> <p>-Interview with CNAs A, B, and O revealed they had not been trained to clean or disinfect the mat between resident use. They stated the mats were cleaned by housekeeping at the end of the day, and then hung to dry. They stated they disinfected the whirlpools between each resident. They would also lower the bath chair and any straps into the tub to be disinfected.</p> <p>-Interview with CNA A confirmed the strap under the mat in hall one's bathing room (photo 24) would have then been dirty and should not be used on a resident. She revealed once the chair and straps were disinfected and cleaned they should have been laid in the chair for the next resident.</p> <p>f. A single-service coffee cup sat on top of an over-the-bed table in hall two's bathing room (photo 12).</p> <p>-Interview with CNA B at the time of the observation confirmed that finding. She stated staff were not allowed to have personal drinks in any resident care areas.</p> <p>-Food and Drink in Resident Care Areas (Employee) policy dated 10/22/07 revealed: --1. Employees will have no food or drinks in resident care areas or during patient care. --2. All employee food and drinks are to remain in the employee lounge except bottled water. --3. a. Patient care areas include but are not limited to: 4. Shower rooms.</p> <p>g. Ensure, a supplemental canned drink, was stored with a piece of tissue wedged into the opened top of the can (photo 14) on hall 3's medication cart.</p> <p>-Interview with CNA M at the time of the observation confirmed that finding. He stated he kept that opened can for a resident, so they could</p>	F 441			

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F 441	<p>Continued From page 82</p> <p>get their required supplemental drinks throughout the day. He stated he had always covered the can in that manner to prevent the liquid from possible contamination.</p> <p>2. Interview on 12/17/14 at 10:35 a.m. with the DON revealed: *She had held stand-up that morning. She stated the following were in attendance: herself, administrator, chief operating officer, dietary manager, Minimum Data Set coordinator, housekeeping/laundry supervisor, and employees X, Y, and Z. -She was asked if there was a record of what was talked about at the stand-up. She replied "no." "Can't remember all that we talked about at stand-up this morning. We discussed isolation precautions. The resident care supervisor (RCS) usually takes notes and keeps track of the topics. No one did that today, and no one kept track of who attended. The RCS's office was locked and we didn't have the book to take notes. No one from maintenance attended as they weren't here."</p> <p>Interview on that same day at 3:00 p.m. with the maintenance supervisor revealed he and the director of plant operations were available for stand-up. They had not been notified of the meeting. If they were not available for a meeting, they would send one of their maintenance people.</p> <p>Surveyor 32572</p> <p>3. Observation and interview on 12/15/14 at 5:06 p.m. of licensed practical nurse (LPN) P revealed she had performed a blood sugar check on resident 30. She placed the glucometer (device used to check blood sugar) on the resident's night stand without a barrier. She then returned the</p>	F 441		

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F 441	Continued From page 83 glucometer to the nurses cart at the nurses station and disinfected it with a Sani-Cloth AF3 germicidal disposable wipe. She had left the disinfectant on for less than one minute. Review of the Sani-Cloth AF3 label revealed a contact time of three minutes. She had not followed the manufacturer's directions of a three minute contact time. She then went to another unidentified resident to perform a blood sugar check. Interview with the LPN at the above time revealed she had been aware of the manufacturers kill time, but stated "I do not have that much time now". 4. Review of the provider's undated Cleaning of Equipment policy revealed "Equipment shall be cleaned between residents using an appropriate cleaning solution or germicidal wipe". Surveyor: 32572 5. Review of the previous licensure surveys on 10/24/12 and 11/20/13 revealed citing of F441 infection control measures of: *Proper glove use. *Proper hand-washing. *Cleaning/disinfecting of resident use items, specifically the glucometer. *Proper cleaning techniques by the housekeeping staff.	F 441			
F 490 SS=L	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial	F 490			

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F 490	<p>Continued From page 84 well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, testing, label review, record review, and policy review throughout the course of the survey from 12/15/14 through 12/18/14 revealed the provider failed to ensure the facility was operated and administered in a manner that attained or maintained the highest practicable physical, mental, and psychosocial well-being of all seventy-two residents. Findings include:</p> <p>1. Interview on 12/16/14 at 7:00 p.m. with the administrator confirmed the overall operation and administration of the facility was her responsibility.</p> <p>Review of the provider's undated job description for Administrator/Chief Executive Officer revealed: *A mission statement of "Our mission is to provide and support health care excellence in partnership with the communities we serve." *An essential job function was to "Establish formal responsibilities and accountabilities of all members of the management and professional staff, and evaluates their performance regularly."</p> <p>2. The following have been cited and/or recited for this licensure survey: F166, F167, *F241, F248, F252, *F253, *F280, *F281, F309, F314, F323, F368, *F441, F493, and F520.</p> <p>3. Review of the last licensure survey completed on 11/20/13 revealed the following deficiencies</p>	F 490	<p>1. Corrective action was taken for affected residents as possible for cited deficiencies.</p> <p>2. All residents have the potential to be affected.</p> <p>3. The Administrator has collaborated with the IDT on policy and process development.</p> <p>4. The Chief Operation Officer (COO) will call and/or visit weekly for 2 months. Any concerns identified will be reported to the Risk QI team for followup.</p>	1/20/15	

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F 493	Continued From page 86 2. Review of the last licensure survey completed on 11/20/13 revealed the following deficiencies had been cited and/or recited (*): *F241, *F253, *F280, *F281, F364, F371, and *F441. 3. Review of a previous licensure survey on 10/24/12 revealed the following deficiencies had been cited: F156, F164, F167, F174, F241, F253, F281, F312, F323, F329, F371, F431, F441, F490, F514, and F520.	F 493		
F 520 SS=L	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET 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.	F 520		

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F 520	Continued From page 87 This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Surveyor: 20031 Based on observation, record review, interview, and policy review, the provider failed to ensure the quality assurance (QA) program identified concerns, needed improvements, and corrective actions to maintain the overall welfare of all the residents, the environment, and the buildings. Findings include: 1. Review of last year's survey on 11/20/13 revealed the following deficiencies had been cited and/or recited (*): *F241, *F253, F280, *F281, F364, *F371, and *F441. 2. Review of a previous survey on 10/24/12 revealed the following deficiencies had been cited: F156, F164, F167, F174, F241, F253, F281, F312, F323, F329, F371, F431, F441, F490, F514, and F520. 3. The current survey had the following deficiencies cited and/or recited (*): F166, *F167, *F241, F248, F252, *F253, *F280, *F281, F309, F314, *F323, F329, F332, F368, *F441, *F490, F493, and *F520. 4. Interview on 12/18/14 at 1:35 p.m. with the director of nursing (DON) confirmed she was responsible for the QA program. She stated the current program used the following to determine concerns: audits, charts, graphs, visual and paper competencies, satisfaction surveys, tracking and trending, and past surveys conducted by the state	F 520	1. The QAPI program has been revised with new policies and procedures to address the lack of root cause analysis, lack of trending, and process for identifying and implementing corrective action. Completed by 1/10/15. 2. As a part of this revision, QI teams will include direct care staff representatives. <i>* The QAPI program leader will be an RN titled Quality Specialist. Direct care staff will be included on the QI teams by 3/1/2015. DNV/SDOH/ME</i>	1/20/15	

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F 520	<p>Continued From page 88</p> <p>department of health. Staff had been educated on the quality assurance performance improvement (QAPI) process. Front line staff were not involved in the QA committee. Staff and department managers that had attended the QA committee meetings were the DON, medical director, physical plant/maintenance, housekeeping/laundry, dietary, social services, activities, pharmacy, and the administrator. She stated QA met monthly. She confirmed the current style of QA was a reactive style and was not proactive and preventative.</p> <p>The DON confirmed:</p> <ul style="list-style-type: none"> *The current style of QA did not track and trend infection control or safety issues. *They did not and had not looked for a root cause (initial problem or base of concern). *The trend reports were used to monitor increases or decreases in an issue. But nothing was done with the trend reports other than a visual report. *The process for identifying and implementing corrective action would be: team discussion, poor outcomes of department audits, and a decline in resident status. <p>Interview with three unidentified (per request) direct care staff regarding QAPI revealed:</p> <ul style="list-style-type: none"> *QAPI was not responsive to concerns or ideas from staff. *QAPI seemed to only look into what they thought they should look at. *QAPI always gave the same old answer "We'll look into it." *They never got any feedback on concerns or questions regarding resident care or safety. *Would have been nice if they did something other than charts, graphs, and audits. 	F 520		

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F 520	<p>Continued From page 89</p> <p>Review of the past four months November, October, September, and August 2014 safety trend reports revealed: *Fourteen resident falls and twenty-five skin incidents in November. Recommendations had been "Increase in resident falls during transfers." *Twenty-one falls and twenty-nine skin incidents in October. Recommendations had been "Frequent fall assessments." *Thirty-six falls and sixteen skin incidents in September. Recommendations had been "Therapy evals [evaluations]." *Twenty-three falls and twenty skin incidents in August. Recommendations had been "Resident safety will be the topic highlited at the next All-Staff meeting to include resident transfers." Review of the past six months from June through November 2014 of QAPI monthly meeting minutes revealed no evidence or discussion in regards to the high numbers of falls and skin incidents. Average census during that time was about seventy residents per day.</p> <p>Review of the provider's undated Quality Improvement policy revealed: **"The ___ Quality Improvement Program provides a planned and systematic process to assure that quality and appropriateness of the resident care provided for all resident are monitored and evaluated, and identified problems are resolved." **"D. Development of the Indicators to Monitor these Important Aspects of Care: 1. These indicators should be objective, measurable and based on current knowledge. They would measure resident outcome or a structure or process that is related to a resident outcome." "E.2. When an actual or potential problem is</p>	F 520		

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F 520	Continued From page 90 identified, it is studied concurrently prospectively and/or retrospectively." "H. The action taken to correct identified problem or to improved the care will be documented. 3. A plan for corrective action and follow-up is developed and implemented."	F 520		

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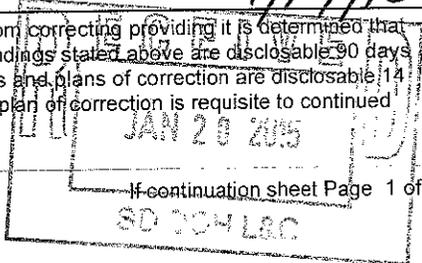
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 12/17/14. Custer Regional Senior Care was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K018, K038, K062, and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>Addendums noted with an asterisk per 1/14/15 telephone to facility plant operations supervisor. LF/KSDDOH/MF</p>	
K 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p>	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *administrator* (X6) DATE: *1/14/15*

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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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain the smoke tight rating of corridor door assemblies at one randomly observed location (resident room door 410). Findings include: 1. Observation at 3:00 p.m. on 12/17/14 during a fire drill revealed a responding staff member that was responsible for closing doors that open to the corridor. That staff member tried to close the resident room door to unit 410. That door was equipped with positive latching hardware. The door to that room was warped, did not allow the positive latching hardware to latch into its frame, and would not stay closed. Interview with the plant operations supervisor at the time the of observation confirmed that condition. He indicated that corridor doors were checked on a monthly basis and all had functioned properly at the time they were last checked. This deficiency has the potential to affect 15 of 76 residents.	K 018	The door identified will be adjusted to close properly. A PM will be generated by the plant operations supervisor to have all the resident room doors inspected on a monthly basis and adjusted as needed. Any and all findings will be reported to the Risk QI team by the plant operations supervisor on an ongoing basis.	1/20/15
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by:	K 038		

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K 038

Continued From page 2
Surveyor: 32334
Based on observation and interview, the provider failed to ensure exits were readily accessible at all times at two of nine marked exits doors to the exterior (front entrance and service door in 400 wing). Findings include:

1. Observation at 10:55 a.m. on 12/17/14 revealed an exit at the main entrance. That door was equipped with a delayed egress magnetic locking device. The signage provided to deactivate that lock advised to "push until alarm sounds and door will open in 15 seconds". Testing of that door revealed it did not alarm when the door was pushed. The door however did open after fifteen seconds. Interview with the plant operations supervisor at the time of the observation and testing revealed he had just had the door hardware service technician on site a few days ago and everything had checked out fine.
2. Observation and testing at 3:10 p.m. on 12/17/14 during a fire drill revealed the magnetic locking device installed on the service wing exterior exit door of the 400 wing did not deactivate. Activation of the building fire alarm system shall deactivate the delayed egress magnetic locking feature installed on that door. Further observation and testing revealed the same condition on the front entrance door just after the 400 wing door was checked. Interview with the plant operations supervisor at the time of observation & testing revealed he was unaware those doors were required to unlock upon activation of the buildings fire alarm system. This deficiency has the potential to affect 76 of 76 residents.

K 038

**delayed egress LFSDDH/MF*
1. The [redacted] alarm identified was repaired 1/6/15.
2. The deficiency identified will be fixed by an outside contractor.
* [redacted] LFSDDH/MF
This will be added to the monthly door alarm PM that is already in use. Any and all issues will be reported to the Risk QI team on an ongoing basis.
**The delayed egress feature will be tied to the fire alarm system to deactivate the magnetic lock upon activation of the fire alarm.*
LFSDDH/MF

1/20/15

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K 062 K 062 SS=E	<p>Continued From page 3</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on record review and interview, the provider failed to ensure the automatic sprinkler system was continuously maintained in reliable operating condition and inspected and tested periodically in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Findings include:</p> <p>1. Document review at 9:00 a.m. on 12/17/14 of the provider's automatic sprinkler system inspection report prepared by Rapid Fire Protection Inc. revealed no documentation of required testing. The automatic sprinkler was installed in 2007, and a five year internal obstruction investigation should have been conducted no later than the year 2012. The documentation provided did not indicate a five year internal obstruction investigation had ever been done.</p> <p>An annual test shall be conducted of the backflow prevention assembly installed on the system riser. The documentation provided did not indicate any testing of the backflow assembly.</p> <p>Interview with the plant operations supervisor at</p>	K 062 K 062	<p>1. The deficiency identified will be done by an outside contractor. The internal obstruction test and the back flow inspection will be added to the contractors check list.</p> <p>An annual PM will be generated by the plant operations supervisor to make sure this procedure is done by the contractor.</p> <p>Any and all issues will be reported to the quarterly Quality Improvement Committee (QIC).</p>	1/20/15

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K 062	Continued From page 4 the time of the record review confirmed that condition. He indicated he was unaware of the five year internal obstruction investigation and backflow testing requirements. This deficiency has the potential to affect 76 of 76 residents.	K 062		
K 144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, record review, and interview, the provider failed to replace the generator battery per NFPA 99 guidelines. Specific gravity testing for the generator battery had not been done since the battery was installed. Findings include:</p> <p>1. Record review at 9:00 a.m. of the generator service report prepared by Cummins Central Power revealed they had performed annual maintenance on the generator on 7/15/14. During that service they had indicated in their comments that the generator battery was outdated and should be replaced.</p> <p>Observation at 1:15 p.m. on 12/17/14 revealed</p>	K 144	<p>1. The deficiency identified has been corrected by a contractor. A new battery and battery cables were installed on 12-18-2014.</p> <p>The contractor has been advised to install any such items as required. PM reports from contractor will be submitted to the Risk QI team.</p>	1/20/15

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K 144	<p>Continued From page 5</p> <p>the generator battery was dated as being replaced on January 2010. Generator batteries should be scheduled for replacement every twenty-four to thirty months. Approximately fifty-nine months had lapsed since the last battery had been installed. The existing battery was of the maintenance free type and incapable of the required weekly specific gravity testing.</p> <p>Interview with the maintenance supervisor at the time of the observation revealed he was aware the battery should have been replaced and believed it had been replaced during the time that generator was serviced. He further reveled he was unaware of the specific gravity testing requirements.</p> <p>This deficiency has the potential to affect 76 of 76 residents.</p>	K 144		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10610 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2014
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S 000	Initial Comments Surveyor: 32334 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 12/15/14 through 12/18/14. Custer Regional Senior Care was found not in compliance with the following requirement: S166.	S 000		
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;	S 166		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

TITLE

CEO

RECEIVED	DATE 1/15/15
	JAN 20 2015

5000-LSC

STATE FORM

6899

KEM311

If continuation sheet of 2

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10610 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2014
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S 166	<p>Continued From page 1</p> <p>(7) Portable space heaters and portable halogen lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to equip light fixtures in tub rooms with lens covers or shatterproof bulbs in three of three tub rooms (100 wing, 200 wing, and 300 wing). Findings include:</p> <p>1. Observation at 11:20 a.m. on 12/17/14 revealed a tub room in the 100 wing. Further observation revealed a heat lamp over the tub. That light fixture was not provided with a lens cover and was not of a shatterproof model. That condition was also found in the 200 wing tub room and in the 300 secured unit tub room. Interview with the plant operations supervisor at the time of the observation confirmed that condition and revealed he was unaware of that requirement.</p>	S 166	<p>1. The deficiency identified will be done by maintenance staff as required. New shatter proof bulbs will be installed. A PM will be generated by the plant operations supervisor to have all lamps in the tub rooms inspected on a monthly basis ongoing. Any and all findings will be reported to the Risk QI team on an ongoing basis.</p>	1/20/15
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