

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

PRINTED: 06/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/07/2014
NAME OF PROVIDER OR SUPPLIER FIRESTEEL HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST 7TH AVENUE MITCHELL, SD 57301		
(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 164	Continued From page 1 contract; or the resident. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to ensure privacy and confidentiality of resident information was maintained about daily stand-up meeting minutes located in an area accessible to residents and visitors (main dining room and shared common area). Findings include: 1. Observation on 5/06/14 at 8:03 a.m. by the main dining room and across from the resident shared common area revealed: *A black, plastic holder affixed to the side of a large, wood plant stand. *In the above holder there was a white binder labeled Stand Up Minutes that contained the following resident information on the Daily Stand Up Meeting minutes: -Admissions. -Hospitalizations. -Discharges. -Room moves. -Falls. -Restraints. -Pressure ulcers. -Weight loss. -Infections. *The above listed information had been in the binder for all meeting minutes from 3/3/14 through 5/5/14. *The holder that contained the above information would have been accessible to a resident in a wheelchair and any other residents or visitors.	F 164			

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F 164	Continued From page 2 Observation on 5/06/14 at 8:10 a.m. at the above location where the binder was located revealed: *Resident 7 transported herself while seated in a wheelchair. *Two unidentified residents walked by. Observation on 5/06/14 at 10:45 a.m. at the location revealed there were ten residents in the commons area. Observation and interview on 5/07/14 at 4:15 p.m. with the director of nursing at the above location regarding the white binder labeled Stand Up Minutes revealed: *The binder contained all meeting minutes from 3/3/14 through 5/07/14. *She agreed the location was accessible to residents and visitors. *She confirmed the Daily Stand Up Meeting minutes contained confidential resident information. *She agreed the location of the minutes was not appropriate. *She immediately removed the white binder containing the minutes from that location. Review of the provider's August 2013 Privacy policy revealed privacy was to have been provided to all residents.	F 164			
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	F241 1. All residents cited in the deficiency had their facial hair removed on or before 5-7-14. 2. All residents are potentially at risk.	6/20/14	

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F 241	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355</p> <p>Based on observation, interview, and policy review, the provider failed to ensure dignity of residents was maintained for six of nine randomly observed residents (2, 25, 26, 27, 28, and 29) who were unshaven. Findings include:</p> <p>1. Random observations from 5/5/14 through 5/6/14 of residents 2, 25, 26, 27, 28, and 29 revealed rough, black, white, and gray facial hair on their lips, chins, and cheeks. During that time frame their facial hair had not been removed or shaved.</p> <p>Interview on 5/6/14 at 2:35 p.m. with resident 27 revealed: *She had not realized she had facial hair on her chin and upper lip. *No staff members had mentioned shaving her chin. *She would not have been shaved until her bath day. *She would have preferred to have had the hair shaved off.</p> <p>Interview on 5/7/14 at 9:10 a.m. with certified nursing assistants A and B revealed: *Both men and women would have been shaved on their bath day. *They would have shaved the residents if they needed it but not daily. *No residents had ever refused to be shaved.</p> <p>Interview on 5/7/14 at 10:20 a.m. with the director of nursing revealed she would have expected the residents to be shaved a minimum of every other day. The staff should have been observant of the</p>	F 241	<p>3.</p> <p>a. Education to all nursing staff will be completed by the DON or designee on or before 6/20/14 on ensuring dignity of residents.</p> <p>b. Director of Nursing or designee will complete written audits of shaving and grooming of residents weekly x 4, then monthly x 2 on dignity/respect of residents on 4 random samples.</p> <p>4. DON or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.</p>		

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F 241	Continued From page 4 residents and their shaving needs. Review of the provider's January 2014 Shaving the Resident policy and procedure revealed the purpose was to promote cleanliness. The policy had not mentioned how often the residents' facial hair should have been removed. Review of the provider's undated Long-term Care Facilities Residents' Bill of Rights pamphlet revealed no documentation to support the provider's responsibility to ensure the resident's appearance was maintained to promote dignity and quality of life.	F 241			
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: 33488 Based on observation and interview, the provider failed to ensure the facility was free of preventable odors in all of the four hallways. Findings include: 1. Random observations from 5/5/14 through 5/7/14 at various times from 7:00 a.m. through 6:00 p.m. in each of the four hallways revealed: *Dirty linen carts remained in each hallway daily. *Staff were observed emptying garbage bags that contained loose soiled clothing from residents' rooms into the carts in the hallway.	F 252	F252 1. No residents cited in the deficiency. Facility associates were educated on the linen / garbage disposal process on or before 5-7-14. 2. All residents are potentially at risk. 3. a. Education to all nursing staff completed by the DON or designee on or before 6/20/14 on ensuring linen carts are stored appropriately when not in use and that soiled linen remains sealed/bagged to prevent odors. b. Director of Nursing or designee will complete written audits weekly x 4, then monthly x 2 on dirty linen/storage procedures on 4 random samples. 4. DON or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	6/20/14	

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F 252	Continued From page 5 *The carts flip top lids had approximately a one inch gap between the bag and the lid. *The carts were not sealable to prevent odors from escaping. *They had remained full for several hours before staff took the soiled items to the soiled utility room. Interview on 5/7/14 at 2:45 p.m. with the director of nursing regarding the above odors revealed she agreed: *There had been an odor problem in the facility. *Disposing loose resident clothing into a dirty linen cart in the hallway was not an appropriate procedure to trap escaping odors.	F 252		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278	F278 1. Resident #6 MDS assessment was modified on 5/9/2014. Resident #14 MDS assessment was modified on 6/3/2014. 2. All residents are potentially at risk. 3. a. Education to all MDS staff and IDT staff completed by the DON or designee on or before 6/20/14 on ensuring accurate coding of assessments. b. Director of Nursing or designee will complete 4 random resident audits weekly x 4, then monthly x 2 on MDS accuracy. 4. DON or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	6/20/14

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F 278	<p>Continued From page 6</p> <p>resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, record review, and interview, the provider failed to have an accurate Minimum Data Set (MDS) assessment for 2 of 21 sampled residents (6 and 14). Findings include:</p> <p>1. Observation and interview on 5/5/14 at 3:45 p.m. with resident 6 revealed she had: *Been at the facility "for about a month." *Surgery prior to coming to the facility which resulted in paralysis (unable to move a part of the body) in her lower limbs. *The ability to move her upper body freely.</p> <p>Review of resident 6's medical record revealed: *She had an admission date of 3/28/14. *She had recently been paralyzed from her mid-back region downward due to complications. *Admission physician's note dated 4/10/14 revealed she was a paraplegic (paralysis in one half of the body), and required "total assist." *She required total dependence on staff for transferring, dressing, hygiene (cleanliness), and bathing. *The 4/4/14 and 4/25/14 MDSs revealed: -Range of motion (body movement) was impaired in her upper extremities (arms). -On section G under functional status of the MDS, she had been coded as needing extensive</p>	F 278		

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F 278	Continued From page 7 assist, which would require the resident to have been involved in the activity. Interview on 5/7/14 at 10:45 a.m. with the MDS coordinator regarding resident 6's MDS revealed: *She had not been unaware of the inaccuracy in the MDS assessment. *Agreed the MDS assessment was not accurate and needed to be corrected. Interview on 5/7/14 at 2:45 p.m. with the director of nursing regarding the accuracy of resident 6's MDS assessment revealed: *Staff had incorrectly filled out the MDS. *The resident's needs were not accurate based on that information. Surveyor: 33265 2. Review of resident 14's medical record revealed: *The 9/16/13 MDS had been coded the resident was on a physician's weight loss plan. *There was no physician's prescribed weight loss regimen or plan. *There was no documentation in the 8/8/13 physician's progress notes for a weight loss plan.	F 278			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	F279 1. Resident #6 care plan was updated on 5/29/14 to be more comprehensive. 2. All residents are potentially at risk. 3. a. Education to all professional nursing and IDT staff completed by the DON or designee on or before 6/20/14 on ensuring care plans are developed and revised according to individual resident needs.	6/20/14	

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F 279	Continued From page 8 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on interview, observation, and record review, the provider failed to accurately develop and revise a comprehensive care plan for one of one sampled resident (6) who was bedbound. Findings include: 1. Observation and interview on 5/5/14 at 3:45 p.m. with resident 6 revealed she: *Was alert and oriented to person, place, and time. *Had been at the facility "for about a month." *Had surgery prior to coming to the facility which resulted in paralysis (unable to move part of the body) from her mid-back down. *Had the ability to move her head, neck, arms, and shoulders but she could not move her lower back and legs. *Was unable to toilet or reposition her lower body herself. *Had acquired a pressure ulcer (injury to the skin and underlying tissue usually over a bony area caused by unrelieved pressure) at the facility after her admission. *Stated the pressure ulcer was "from not being	F 279	b. Director of Nursing or designee will complete 4 random resident audits weekly x 4, then monthly x 2 on care plan accuracy. 4. DON or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.		

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F 279	<p>Continued From page 9</p> <p>repositioned in my wheelchair. I am on bed rest so it doesn't get worse." *Had been bedbound for one week. *Had been repositioned "once a day if I'm lucky, sometimes two or three times a day. The only moving I usually get is when they turn me over [temporarily] in bed when they change me. I have to ask them to reposition me." *Stated prior to being placed on bed rest staff had been transferring her to the commode for toileting. *Had not used the commode for toileting since being on bed rest, staff would change her brief (disposable undergarment) while she had been in bed. *Had been on a fluid restriction since admitted and was unaware why she was still on the fluid restriction.</p> <p>Review of resident 6's medical record revealed: *She had been admitted to the facility on 3/28/14. *She had recently been paralyzed from her mid-back region downward due to complications. *The 4/10/14 physician's admission note stated she was a paraplegic (paralysis in one half of the body), and she required "total assist." *She was a high risk for pressure ulcers as her Braden score (tool to assess skin breakdown risk) was 13. A score of 17 or below indicates high risk. *A 4/29/14 physician's order included: -"No sacral (location where back and buttocks meet) or reclined sitting" related to new pressure ulcers that had developed on 4/22/14. -"Pressure shifts every twenty minutes for sore prevention." *There was no documentation of any laboratory results.</p>	F 279			

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F 279	<p>Continued From page 10</p> <p>Review of resident 6's 5/5/14 care plan revealed: *The last care plan review had been completed on 4/11/14, and contained the following entries of: -Her bowel program was "suppository then up on commode with digital stimulation." -"I would like staff to assist with activities of daily living (ADLs) as needed. I am to reposition before and after meals, at bedtime and on rounds at night." -"Staff to use sliding board for transfers from bed to wheelchair, and transfer back to bed HS (bedtime)/naps." -"I will change my position in my wheelchair (w/c) for thirty minutes at a time to assist with my balance." -Fluid restriction of 2000 milliliters per day. *"Nurse to measure and evaluate active wounds and treatment protocols weekly and as needed, and update MD (medical doctor) with progress." *She was totally dependent on staff for all cares involving her lower extremities. *She was unable to reposition herself. *The 4/29/14 physician's order revealed no sacral sitting. *She had not been using the commode for toileting. *She no longer transferred to a wheelchair. *It did not include the physician's order to reposition her every twenty minutes to prevent sores. *There was no documentation to reposition her every twenty minutes to prevent pressure ulcers. *No clarification was done by the provider to confirm the need for continued fluid restriction. *Her pressure ulcers were measured weekly and not as needed.</p> <p>Review of the medical record for resident 6</p>	F 279		

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F 279	<p>Continued From page 11 revealed:</p> <ul style="list-style-type: none"> *Progression of the ulcer had gone unmentioned in notes by staff until it had been measured again during the weekly assessment. *She had dressing changes twice daily. *Wounds measurements had not been documented to monitor for progression of the ulcer as care planned. <p>Interview on 5/5/14 at 4:00 p.m. and at 6:05 p.m. with registered nurse (RN) E regarding resident 6 revealed:</p> <ul style="list-style-type: none"> *She had acquired the pressure ulcer after admission to the facility. *She "should be repositioned every 2 hours or so, and before and after meals." *The certified nursing assistants (CNA) charted once per shift that she had been repositioned. *There were no laboratory blood tests ordered on her since her admission to the facility to validate the continued need for fluid restriction. <p>Interview on 5/7/14 at 2:45 p.m. with the director of nursing (DON), the director of clinical services consultant, and the nurse manager of the west hall regarding resident 6's care plan revealed:</p> <ul style="list-style-type: none"> *She had been bedbound for one week prior to the time of the survey to prevent worsening of a facility aquired sacral ulcer. *They agreed her ulcer had worsened since aquired. *They agreed there needed to have been increased times of skin assessments since the pressure ulcer had worsened. *They agreed staff had not updated her care plan to reflect the current level of care needed. *They agreed the physician's order for repositioning every twenty minutes had not been care planned and had not been done as ordered. 	F 279			

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F 279	Continued From page 12	F 279			
F 281 SS=D	<p>*They agreed the above mentioned fluid restriction should have been followed up on by staff to see if the order was still needed and adjusted the care plan accordingly.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to: *Appropriately assess, monitor, intervene, follow physician's orders, and document changes for one of one sampled bedbound resident (6) with a new or worsening pressure ulcer. *Clarify a physician's order for use of a knee immobilizer for one of one resident (1) wearing a knee immobilizer. *Properly administer a nebulizer treatment to one of one resident (1) who wore a simple face mask for routine oxygen delivery. Findings include:</p> <p>1. Observation and interview on 5/5/14 at 3:45 p.m. with resident 6 revealed she: *Had been at the facility "for about a month." *She had recently been paralyzed from her mid-back region downward due to complications. *Had acquired a pressure ulcer at the facility after her admission "from not being repositioned in my wheelchair. I am on bed rest so it doesn't get worse." *Had been bedbound for one week.</p>	F 281	<p>F281</p> <p>1. Resident #6 had on-going interventions in place at the time of the survey and post survey to ensure professional standards were met. Resident #1 unable to correct in regards to splint and also has a new type of mask for his oxygen and nebulizer treatment.</p> <p>2. All residents are potentially at risk.</p> <p>3.</p> <p>a. Education to all professional nursing staff completed by the DON or designee on or before 6/20/14 on ensuring professional standards are being followed.</p> <p>b. Director of Nursing or designee will complete 4 random written audits weekly x 4, then monthly x 2 on professional standards. The sample selection is random. The following will be audited. 1. Appropriately assess, monitor, intervene, following physician orders, and document changes. 2. Physician orders are clarified if not clear. 3. Nebulizers are administered appropriately. 4. DON or designee will report results of the audits to the facility QAPI</p>	6/20/14	

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F 281	<p>Continued From page 13</p> <p>*Was lying on her back.</p> <p>*Stated staff had not repositioned her since that morning.</p> <p>*Would be repositioned "once a day if I'm lucky, sometimes two or three times a day. The only moving I usually get is when they turn me over [temporarily] in bed when they change me. I have to ask them to reposition me."</p> <p>Interview on 5/5/14 at 4:00 p.m. and at 6:05 p.m. with registered nurse (RN) E regarding resident 6 revealed:</p> <p>*She had acquired her pressure ulcer after her admission to the facility.</p> <p>*She "should be repositioned every two hours or so, and before and after meals."</p> <p>*The certified nursing assistants (CNA) charted once per shift that she had been repositioned.</p> <p>Review of resident 6's medical record revealed:</p> <p>*She was admitted on 3/28/14 from the hospital.</p> <p>*She was unable to reposition herself.</p> <p>*She was dependent on staff for all care involving her lower extremities.</p> <p>*The 4/10/14 admitting physician's note stated she was a paraplegic (paralysis in one half of the body) and required "total assist."</p> <p>*She was at high risk for pressure ulcers.</p> <p>*She had a pressure redistribution mattress on her bed.</p> <p>Daily Skilled Nursing Assessment and nurses note documentation provided by the director of clinical services and the director of nursing (DON) revealed:</p> <p>a. Nurses note on 4/19/14 revealed "Coccyx (tailbone) beginning to become reddened with very little blanching (return of skin color after slight pressure applied). Will update unit manager</p>	F 281			

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F 281	<p>Continued From page 14 for assessment."</p> <p>b. The Skilled Nursing Assessment dated 4/19/14, a pressure ulcer to the coccyx was noted, but no assessment had been completed.</p> <p>c. Nurses note on 4/21/14 revealed: "Noted open area to crease of buttock, may we have order to cleanse with saline, apply hydrogel (a dressing used to promote healing and protection of wounds) change daily and as needed if soiled?"</p> <p>d. The Skilled Nursing Assessment dated 4/20/14 it stated there were "no skin issues" and added a pressure relieving cushion. No assessment had been completed.</p> <p>e. The Skilled Nursing Assessment dated 4/21/14 it stated "new slit to coccyx." No assessment had been completed.</p> <p>f. The Skilled Nursing Assessment dated 4/22/14 stated: ***"Wound location: coccyx." ***"Wound treatment daily." ***"Describe wounds (include description, location, and size of each), white wound bed at pressure ulcer." No other assessment data had been completed.</p> <p>g. The Skilled Nursing Assessment dated 4/23/14 under the skin section listed the wound as being located at coccyx with treatment scheduled daily. No assessment had been completed.</p> <p>h. The Skilled Nursing Assessment dated 4/28/14 stated "resident is to be repositioned every two hours to alleviate pressure on bottom" and three blisters were noted on the residents right buttock. No further assessment had been noted. *Skilled Nursing assessments continued daily and did not include complete assessment data. *Wound care assessments were performed weekly on a Weekly Wound Documentation Form. *A physician's order noted on 4/29/14 read:</p>	F 281		

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F 281	<p>Continued From page 15</p> <p>-"No sacral (location where back and buttocks meet) or reclined sitting" related to pressure ulcers that had developed on 4/22/14.</p> <p>-"Pressure shifts every twenty minutes for sore prevention."</p> <p>*The care plan had not included the physician's order to reposition every twenty minutes to prevent sores.</p> <p>*The Skilled Nursing Assessment in the Functional section prompted staff to enter "Positioning: turn schedule." That had not been completed as directed by the provider's own assessment documentation tool.</p> <p>*It stated in the skin assessment section to "Describe wounds (include description, location, and size of each)."</p> <p>*That had not been completed as directed by the provider's own assessment documentation tool.</p> <p>*Staff would have no way of knowing the stage or severity of the wound without completing an accurate wound assessment more frequently than once per week as indicated and allowed in the care plan.</p> <p>Observation and interview on 5/7/14 from 10:05 a.m. through 10:30 a.m. with registered nurse (RN) F performing a dressing change on resident 6's pressure ulcer revealed:</p> <p>*Two unstageable areas, one in the center and one surrounding a blistered area [measured by the nurse specifically for this observation] totaled approximately 9 centimeters (cm) in length by 7.5 cm in width.</p> <p>*The larger outer unstageable area had occurred since 5/5/14.</p> <p>-RN F remarked, "well that's new [referring to the new unstageable area]."</p> <p>*When asked how how staff would know if the ulcer had worsened since the last weekly</p>	F 281			

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F 281	<p>Continued From page 16 measurement if it was not fully assessed daily RN F stated, "Well that's a good question, I guess we wouldn't."</p> <p>Interview on 5/7/14 at 2:45 p.m. with the director of nursing (DON), the director of clinical services consultant, and the nurse manager for the west hall regarding resident 6's pressure ulcer revealed:</p> <ul style="list-style-type: none"> *They agreed the pressure ulcer had been acquired since her admission to the facility. *They agreed it had worsened and to an unstageable area of deep tissue injury. *They agreed the physician's order for repositioning should have been followed. *They agreed the only way to show progression of a wound would be to perform a complete assessment daily that included measurements, however they were only "required to do weekly measurements." *Without measurements staff would not have known if the pressure ulcer had worsened. *The physician should have been notified of the new area. *The DON stated the physician would be coming to the facility the next day, and they would notify him then. "It'll save us a trip to Sioux falls" to a wound care specialist that day, as that was "probably what he [doctor] will do anyway." *They agreed more documentation had been needed related to any nurse assessment, monitoring, and intervention. <p>Review of the provider's revised August 2013 Skin Assessment policy revealed:</p> <ul style="list-style-type: none"> *A Braden Scale (skin assessment tool) was one assessment that would have been completed by the nurse manager or RN designee in the event of major changes or an admission. 	F 281		

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F 281	<p>Continued From page 17</p> <p>*Since admission on 3/28/14 only one admission Braden Assessment was completed.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, Chapter 48-Skin integrity and Wound Care, pages 1176-1229, revealed:</p> <p>***Nurses constantly observe for skin integrity and identify at-risk patients from developing pressure sores. Nursing interventions focus on prevention.</p> <p>***Nurses understand factors affecting pressure ulcer formation and wound healing.</p> <p>***Nurses apply the WOCN (wound, ostomy, and continence nurse) standards for prevention of pressure sores and assessment for skin integrity, prevention and treatment."</p> <p>Review of Madeleine Flanagan's Wound Healing and Skin Integrity- Principles and Practice, 1st Ed., Hoboken, NJ, 2013, pages 128-133, revealed:</p> <p>***A comprehensive skin inspection should be conducted to ascertain the presence of pressure ulcers or observable pressure related changes."</p> <p>***Skin inspections should be conducted and documented by educated clinicians."</p> <p>***Frequency and repositioning is dependent upon the individuals tissue tolerance to pressure and not times that suit care routines. Routine skin inspections on repositioning for signs of pressure compromise will indicate if the individual is being repositioned as frequently as needed. Continuing repositioning is required even when pressure redistribution surfaces are used."</p> <p>***Regular repositioning and selection of an appropriate support surface are crucial elements for the prevention and management of pressure ulcers."</p> <p>***Referral is needed if evidence of decreased</p>	F 281		

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F 281	<p>Continued From page 18 tissue perfusion."</p> <p>Review of the document provided by the director of clinical services consultant and the DON on 5/7/14 at 6:30 p.m. labeled Guidance to Surveys-F Tag 314, Support Surfaces and Redistribution, paragraph 2, subsection 1, regarding pressure redistribution devices states "the cushion does not eliminate the necessity for repositioning."</p> <p>Review of the document provided by the director of clinical services consultant and the DON on 5/7/14 at 6:30 p.m. labeled Alternating Pressure Mattress with Low Air Loss had not stated in its documentation that repositioning was not needed when using a redistribution mattress.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 358, revealed, "A registered nurse makes a telephone report when significant events or changes in a patient's condition have occurred."</p> <p>Review of Gefin A., "Ostomy Wound Management," How much time does it take to get a pressure ulcer? October 2008 www.ncbi.nlm.nih.gov/pubmed/18927481 <http://www.ncbi.nlm.nih.gov/pubmed/18927481> revealed "pressure ulcers in subdermal tissue (below the skin) under bony prominences very likely occur between the first hour and four to six hours after sustained loading." Surveyor: 33265 2. Review of resident 1's medical record revealed: *On 1/18/14 a fracture of the right distal femur (bottom part of long bone of upper thigh) of unknown cause had been identified. *The resident returned from dialysis and having</p>	F 281			

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F 281	<p>Continued From page 19</p> <p>X-rays with the right leg in a "half splint" with "ace wrap in place."</p> <p>*On 1/28/14 at the follow-up clinic appointment the half splint was removed. Upon removal of the half splint two pressure ulcers were found, one on the top part of the right foot and one on the right heel.</p> <p>*The resident then returned to the facility with a knee immobilizer in place on the right leg.</p> <p>*Orders were:</p> <ul style="list-style-type: none"> -No pressure to the foot or the heel. -Check the skin daily for new breaks in the skin. -Keep the knee immobilizer on at all times. -Follow-up in four weeks with follow-up X-rays. <p>*There had been no clarification of the orders to determine if the knee immobilizer could be loosened or removed daily to clean and check the skin under the brace.</p> <p>*On 2/25/14 at 3:58 p.m. during a skin assessment a registered nurse noted there had been deep tissue injury to the right front calf just below the knee and an open area to the back of the lower right leg.</p> <p>*A call had been placed to the orthopedic physician. Results were:</p> <ul style="list-style-type: none"> -A physician assistant stated "he looked at the leg while the resident was at the clinic today." -Facility received orders to "continue leg brace, may loosen Velcro while in bed." -Wound treatment orders would be requested from the primary physician. <p>Interview on 5/7/14 at 3:30 p.m. with the DON revealed:</p> <ul style="list-style-type: none"> *She believed the two pressure ulcers from the first half splint were unavoidable. *She stated her staff followed orders received from the physician concerning the orthopedic devices utilized. The knee immobilizer was kept 	F 281			

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F 281	<p>Continued From page 20 on at all times. *She believed skin assessments were completed daily.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013, revealed: *Pages 499-500: The risk for skin impairment "increases if there is pressure against the skin when the patient is immobile [not moving]." At high risk are patients who are neurologically impaired or chronically ill or have had orthopedic or vascular injuries. Also at higher risk are patients with diminished mental status, poor tissue oxygenation, or inadequate nutrition." Patients in nursing homes are often at high risk for similar problems, depending on their level of mobility and the present of chronic illness. Routinely assessment of the skin of all at-risk patients to look for primary or initial lesions that develop. Without proper care primary lesions can deteriorate to become secondary lesions that require more extensive nursing care."</p> <p>3. Observation and interview on 5/6/14 at 3:09 p.m. of certified nursing assistant (CNA)/medication (med) aide P regarding resident 1 revealed: *The resident was receiving oxygen per face mask. *She confirmed she had set-up the nebulizer treatment about five to ten minutes ago and had attempted to start the nebulizer, but the resident had resisted. *She started the nebulizer machine and snugly fitted the nebulizer face mask directly over the oxygen mask already in place. The two masks were fitted together, the nebulizer mask was stacked on top of the original oxygen mask.</p>	F 281		

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F 281	Continued From page 21 *When asked why the masks were stacked she stated the resident needed the oxygen or his oxygen saturation (amount of oxygen carried in blood) dropped too much during nebulizer treatments. *When asked how the medication from the nebulizer could get through, she stated there were holes in each mask. *She then left the resident's room with the nebulizer machine on. Interview on 5/7/14 at 3:30 p.m. with the DON regarding resident 1 revealed she: *Had not known about the double-masking until this morning. *Supported the double-masking, because the resident needed the oxygen during the nebulizer treatments. They had tried a nasal cannula (plastic tubing with prongs going into the nostrils of the nose) and the resident had chewed through the nasal cannula tubing. *Was unaware of other nebulizer set-ups that had an oxygen port for attaching oxygen during nebulizer treatments. Review of Donna D. Ignatavicius and M. Linda Workman, Medical Surgical Nursing Patient-Centered Collaborative Care, 7th Ed., Elsevier, St. Louis, Mo., 2013, revealed: *Page 567: A diagram of the simple facemask. The exhalation ports (holes) on the sides were identified. The original face mask design would prevent air or medication from the second mask getting to the patient.	F 281			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		6/20/14	

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F 314	<p>Continued From page 22</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to prevent new or worsening pressure ulcers for one of five sampled residents (6). Findings include:</p> <p>1. Observation and interview on 5/5/14 at 3:45 p.m. with resident 6 revealed she: *Had been at the facility "for about a month." *She had recently been paralyzed from her mid-back region downward due to surgical complications. *Had acquired a pressure ulcer at the facility after her admission "from not being repositioned in my wheelchair. I am on bed rest so it doesn't get worse." *Had been bedbound for one week. *Was lying on her back. *Stated staff had not repositioned her since that morning. *Would be repositioned "once a day if I'm lucky, sometimes two or three times a day. The only moving I usually get is when they turn me over [temporarily] in bed when they change me. I have to ask them to reposition me." Interview on 5/5/14 at 4:00 p.m. and at 6:05 p.m.</p>	F 314	<p>F314</p> <p>1. Resident #6 facility had requested a treatment order change on 5/5/13 at 11:53 am prior to surveyors entering the building. Orders were received by Firesteel nurse for a new treatment on 5/6/14 and new orders have been implemented since the survey to prevent worsening of her pressure.</p> <p>2. All residents are potentially at risk.</p> <p>3.</p> <p>a. Education to all nursing staff and dietary staff to be completed by the DON or designee on or before 6/20/14 on ensuring pressure ulcers are being treated appropriately.</p> <p>b. Director of Nursing or designee will complete written audits weekly x 4, then monthly x 2 on pressure ulcer standards. Residents with pressure ulcers will be audited with a maximum of 4 samples. The following areas will be audited: 1. Checking to ensure prevention measures are in place prior to open areas developing or at time of identification (ie: air bed, wheelchair cushion, floatation of heel). 2. Was the pressure area avoidable or unavoidable. 3. Is there a treatment in place to promote healing and prevention of infection.</p>	6/20/14	

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F 314	<p>Continued From page 23 with registered nurse (RN) E regarding resident 6 revealed:</p> <ul style="list-style-type: none"> *She had acquired the pressure ulcer after admission to the facility. *She "should be repositioned every 2 hours or so, and before and after meals." *The certified nursing assistants (CNA) charted once per shift that she had been repositioned. *There were no laboratory blood tests ordered on her since her admission to the facility to validate the continued need for fluid restriction. <p>Observation on 5/6/14 at 11:00 a.m. of resident 6 revealed:</p> <ul style="list-style-type: none"> *Her eyes were closed. *She was lying on her back. <p>Observation on 5/6/14 at 12:00 noon of resident 6 revealed:</p> <ul style="list-style-type: none"> *Her eyes were closed. *She was lying on her back. <p>Observation and interview on 5/6/14 at 4:15 p.m. with resident 6 revealed:</p> <ul style="list-style-type: none"> *She was lying on her back. *She had a wedge pillow under her right side. <p>Observation and interview on 5/6/14 at 6:00 p.m. with resident 6 revealed:</p> <ul style="list-style-type: none"> *She was lying on her back with the wedge pillow under her right side. *She had not been repositioned since 4:15 p.m. <p>Interview on 5/6/14 at 6:05 p.m. with registered nurse (RN) E regarding resident 6 revealed:</p> <ul style="list-style-type: none"> *The resident had acquired her pressure ulcer after admission to the facility. *The resident should have been repositioned every two hours and before and after meals. 	F 314	4. DON or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.		

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F 314	<p>Continued From page 24</p> <p>*The certified nursing assistants were only "flagged" to chart repositioning once per shift.</p> <p>*When asked her how the staff would know then how often the resident had been repositioned she stated, "Not sure, but that's what she's been getting."</p> <p>*The resident was "turned every four hours at night per her own request, so she could sleep."</p> <p>Observation and interview on 5/7/14 at 8:20 a.m. with resident 6 revealed:</p> <p>*She was flat on her back.</p> <p>*Her wedge pillow lay across the top of her legs.</p> <p>*She had not been repositioned yet this morning.</p> <p>*She appeared very tired and weak.</p> <p>*She had a cough and felt "worse."</p> <p>Interview on 5/7/14 at 10:05 with RN F regarding the repositioning of resident 6 revealed the resident had pulled her wedge pillow out herself this morning due to pain.</p> <p>Observation and interview on 5/7/14 from 10:05 a.m. through 10:30 a.m. with registered nurse (RN) F performing a dressing change on resident 6's pressure ulcer revealed:</p> <p>*Two unstageable areas, one in the center and one surrounding a blistered area [measured by the nurse specifically for this observation] totaled approximately 9 centimeters (cm) in length by 7.5 cm in width.</p> <p>*The larger outer unstageable area had occurred since 5/5/14.</p> <p>-RN F remarked, "well that's new [referring to the new unstageable area]."</p> <p>*When asked how how staff would know if the ulcer had worsened since the last weekly measurement if it was not fully assessed daily RN F stated, "Well that's a good question, I guess we wouldn't."</p>	F 314		

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F 314	Continued From page 25 Observation and interview on 5/7/14 at 10:35 a.m. with resident 6 revealed: *She had pulled her wedge pillow out, because it had "hurt [her back] badly." *It had been too long since her last repositioning, and she "couldn't take it anymore." Interview on 5/7/14 at 2:45 p.m. with the director of nursing (DON), the director of clinical services consultant, and the nurse manager for the west hall regarding resident 6's pressure ulcer revealed: *They agreed the pressure ulcer had been acquired since her admission to the facility. *They agreed it had worsened and to an unstageable area of deep tissue injury. *They agreed the physician's order for repositioning should have been followed. *They agreed the only way to show progression of a wound would be to perform a complete assessment daily that included measurements, however they were only "required to do weekly measurements." *Without measurements staff would not have known if the pressure ulcer had worsened. *The physician should have been notified of the new area. *The DON stated the physician would be coming to the facility the next day, and they would notify him then. "It'll save us a trip to Sioux falls" to a wound care specialist that day, as that was "probably what he [doctor] will do anyway." *They agreed more documentation had been needed related to any nurse assessment, monitoring, and intervention. Review of resident 6's medical record revealed: *She was admitted on 3/28/14 from the hospital. *She was unable to reposition herself.	F 314			

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F 314	<p>Continued From page 26</p> <p>*She was dependent on staff for all cares involving her lower extremities.</p> <p>*The 4/10/14 admitting physician's note stated she was a paraplegic (paralysis in one half of the body) and required "total assist."</p> <p>*She was at high risk for pressure ulcers.</p> <p>*She had a pressure redistribution mattress on her bed.</p> <p>Daily Skilled Nursing Assessment and nurses note documentation provided by the director of clinical services and the director of nursing (DON) revealed:</p> <p>a. Nurses note on 4/19/14 revealed "Coccyx (tailbone) beginning to become reddened with very little blanching (return of skin color after slight pressure applied). Will update unit manager for assessment."</p> <p>b. The Skilled Nursing Assessment dated 4/19/14, a pressure ulcer to the coccyx was noted, but no assessment had been completed.</p> <p>c. Nurses note on 4/21/14 revealed: "Noted open area to crease of buttock, may we have order to cleanse with saline, apply hydrogel (a dressing used to promote healing and protection of wounds) change daily and as needed if soiled?"</p> <p>d. The Skilled Nursing Assessment dated 4/20/14 it stated there were "no skin issues" and added a pressure relieving cushion. No assessment had been completed.</p> <p>e. The Skilled Nursing Assessment dated 4/21/14 it stated "new slit to coccyx." No assessment had been completed.</p> <p>f. The Skilled Nursing Assessment dated 4/22/14 stated:</p> <p>***"Wound location: coccyx."</p> <p>***"Wound treatment daily."</p> <p>***"Describe wounds (include description, location, and size of each), white wound bed at pressure</p>	F 314		

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F 314	<p>Continued From page 27</p> <p>ulcer." No other assessment data had been completed.</p> <p>g. The Skilled Nursing Assessment dated 4/23/14 under the skin section listed the wound as being located at coccyx with treatment scheduled daily. No assessment had been completed.</p> <p>h. The Skilled Nursing Assessment dated 4/28/14 stated "resident is to be repositioned every two hours to alleviate pressure on bottom" and three blisters were noted on the residents right buttock. No further assessment had been noted.</p> <p>*Skilled Nursing assessments continued daily and did not include complete assessment data.</p> <p>*Wound care assessments were performed weekly on a Weekly Wound Documentation Form.</p> <p>*A physician's order noted on 4/29/14 read: -"No sacral (location where back and buttocks meet) or reclined sitting" related to pressure ulcers that had developed on 4/22/14. -"Pressure shifts every twenty minutes for sore prevention."</p> <p>*The care plan had not included the physician's order to reposition every twenty minutes to prevent sores.</p> <p>*The Skilled Nursing Assessment in the Functional section prompted staff to enter "Positioning: turn schedule." That had not been completed as directed by the provider's own assessment documentation tool.</p> <p>*It stated in the skin assessment section to "Describe wounds (include description, location, and size of each)."</p> <p>*That had not been completed as directed by the provider's own assessment documentation tool.</p> <p>*Staff would have no way of knowing the stage or severity of the wound without completing an accurate wound assessment more frequently than once per week as indicated and allowed in</p>	F 314			

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F 314	<p>Continued From page 28 the care plan.</p> <p>Review of the provider's revised August 2013 Skin Assessment policy revealed: *A Braden Scale (skin assessment tool) was one assessment that would have been completed by the nurse manager or RN designee in the event of major changes or an admission. *Since admission on 3/28/14 only one admission Braden Assessment was completed.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, Chapter 48-Skin integrity and Wound Care, pages 1176-1229, revealed: **"Nurses constantly observe for skin integrity and identify at-risk patients from developing pressure sores. Nursing interventions focus on prevention." **"Nurses understand factors affecting pressure ulcer formation and wound healing." **"Nurses apply the WOCN (wound, ostomy, and continence nurse) standards for prevention of pressure sores and assessment for skin integrity, prevention and treatment."</p> <p>Review of Madeleine Flanagan's Wound Healing and Skin Integrity- Principles and Practice 1st Ed., Hoboken, NJ, 2013, pages 128-133, revealed: **"A comprehensive skin inspection should be conducted to ascertain the presence of pressure ulcers or observable pressure related changes." **"Skin inspections should be conducted and documented by educated clinicians." **"Frequency and repositioning is dependent upon the individuals tissue tolerance to pressure and not times that suit care routines. Routine skin inspections on repositioning for signs of pressure compromise will indicate if the individual is being</p>	F 314		

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F 314	<p>Continued From page 29</p> <p>repositioned as frequently as needed. Continuing repositioning is required even when pressure redistribution surfaces are used." **"Regular repositioning and selection of an appropriate support surface are crucial elements for the prevention and management of pressure ulcers." **"Referral is needed if evidence of decreased tissue perfusion."</p> <p>Review of the document provided by the director of clinical services consultant and the DON on 5/7/14 at 5:00 p.m. Turned and Repositioned Log documented by the CNAs revealed times of approximately every eight hours for turning and repositioning.</p> <p>Review of the document provided by the director of clinical services consultant and the DON on 5/7/14 at 6:30 p.m. labeled Guidance to Surveys- F Tag 314, Support Surfaces and Redistribution, paragraph 2, subsection 1, regarding pressure redistribution devices states "the cushion does not eliminate the necessity for repositioning."</p> <p>Review of the document provided by the director of clinical services consultant and the DON on 5/7/14 at 6:30 p.m. labeled Alternating Pressure Mattress with Low Air Loss had not stated in its documentation that repositioning was not needed when using a redistribution mattress.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 358, revealed, "A registered nurse makes a telephone report when significant events or changes in a patient's condition have occurred."</p> <p>Review of Gefin A., "Ostomy Wound</p>	F 314		

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F 314	Continued From page 30 Management," How much time does it take to get a pressure ulcer? October 2008 www.ncbi.nlm.nih.gov/pubmed/18927481 < http://www.ncbi.nlm.nih.gov/pubmed/18927481 > revealed "pressure ulcers in subdermal tissue (below the skin) under bony prominences very likely occur between the first hour and four to six hours after sustained loading."	F 314	F323 1. No residents cited in the deficiency. 2. All residents are potentially at risk. 3. a. The door was fixed immediately & all other items were fixed by 05/09/2014. b. Education to all staff to be completed by the DON or designee on or before 6/20/14 on ensuring proper storage of laboratory specimens and hazardous chemicals. Education to also include ensuring that when the doors are tested that all doors can be opened with minimal force by residents in the event of an emergency. c. Director of Nursing or designee will complete written audits weekly x 4, then monthly x 2 on ensuring a safe/ accident free environment. Audit selection is random with a maximum of four. The following areas will be audited: 1. Residents do not have access to biohazardous laboratory specimens/materials. 2. Tub rooms to ensure all chemicals are stored properly on the bottom shelves as to avoid contamination of resident care items. 3. All nurses stations to ensure their personal items are not stored inappropriately.		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, testing, manufacturer's product information, and policy review, the provider failed to: *Ensure residents did not have access to unmonitored biohazardous laboratory specimens at one of three nurses stations (central hall). *Failed to ensure resident's personal care items had not been stored and commingled with hazardous chemicals in two of three bathing rooms (central and south hall). *Failed to ensure one of seven exit doors (building 2 of central hall) could be opened with minimal force by residents in case of an emergency. Findings include:	F 323		6/20/14	

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F 323	Continued From page 31 Surveyor 33265 1. Observation on 5/7/14 from 8:40 a.m. to 9:20 a.m. at the center nurses station revealed: *Two vials of red fluid in a red biohazard bag placed on the edge of the counter. *Other items in the immediate area included a: -Medium, tall plastic bucket with fluid in the bottom and a red biohazard bag liner. -Plastic box of games (cards and other items) with an unsecured lid for the residents to use. -Staff member's drinking cup with a straw. -Used hair brush. *That center nurses station had been unattended. *Several staff members had walked through the nurses station during the observation period without acknowledgement of the above items. *Numerous residents and visitors stopped at the nurses station during the observation period. Surveyor 33488 2. Observation on 5/5/14 from 3:00 p.m. through 4:30 p.m. of two of three facility bathing rooms, (central and south), revealed: *In the central hall bathroom, a cupboard located in the contained the following resident's personal care items commingled with chemicals (photo 2a): -One box Curad Band-Aids. -One opened pack of gauze 4 by 4 bandages. -One bottle of Iron Out (rust and stain remover). -One spray bottle Super HDQ 10 (disinfectant). -One container of Sani-wipes. -One box of twin blade razors. -One bottle of Top Job (bleach). -Two tubs of Turtle Wax. -A stack of washcloths. -One package of disposable undergarments. -Two bottles of Penner Classic Whirlpool	F 323	4. DON or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	

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F 323	<p>Continued From page 32</p> <p>Disinfectant Cleaner.</p> <p>*In the south hall bathing room a cupboard contained the following resident's personal care items commingled with chemicals (photo 2b):</p> <ul style="list-style-type: none"> -One package of disposable undergarments. -Two bottles of Top Job (bleach). -One spray bottle of Super HDQ 10 (disinfectant). -Two bottles of Penner Classic Whirlpool Disinfectant Cleaner. -One tub of Turtle Wax. <p>The Material Safety Data Sheets (MSDS) for the above mentioned chemicals side effects when in contact with the following routes of exposure included but were not limited to:</p> <p>*Eyes: burning sensation, watering, redness, irritation, pain, swelling, tissue damage and substantial eye injury.</p> <p>*Skin: redness, irritation, burning, tissue destruction, permanent damage to skin, corrosion of mucous membranes (linings of skin located at lips, mouth, nose, eyelids, ears, genitals, and anus).</p> <p>*Inhalation (breathing): irritation, burning, dizziness, headache, and corrosion of mucous membranes, severe tracheal (windpipe) burns, difficulty breathing, and coughing.</p> <p>3. Observation and testing on 5/6/14 at 8:15 a.m. of the exit door down the central hall revealed the exit door could not be opened with minimal force by this surveyor.</p> <p>4. Interview and tour of the facility with the maintenance supervisor on 5/6/14 at 4:05 p.m. regarding the above exit door and chemicals revealed:</p> <p>*This surveyor demonstrated difficulty in opening the door.</p>	F 323			

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F 323	<p>Continued From page 33</p> <p>*The maintenance supervisor agreed in the event of an emergency it would take more than minimal force to open the door. *He had been unaware of its condition. *Nurses only opened the door when checking alarm status but had not advised him of the issue. *Agreed all doors needed to be checked for safety and included in a routine maintenance plan. *Agreed chemicals were not to be commingled with resident's personal care items and could pose a serious hazard to residents.</p> <p>Observation and interview on 5/6/14 at 6:10 p.m. of the above bathing room cupboards with the administrator revealed: *She had been unaware of the chemicals stored with resident's personal care items. *Agreed chemicals were not to be commingled with resident's personal care items and could pose a serious hazard to residents. *It had been her expectation staff would not store resident's personal care items and chemicals in the same cupboard.</p> <p>Interview on 5/7/14 at 2:45 p.m. with the director of nursing (DON) and the director of clinical services consultant regarding the above observations revealed: *The DON had been unaware that biohazardous laboratory specimens containing blood were left at the nurses station unmonitored and accessible to residents and visitors. *It was her expectation biohazardous laboratory specimens were monitored if they were placed at the central nurses station for laboratory pickup. *She had been unaware of difficulty opening the exit door down the central hall and agreed that was a safety hazard.</p>	F 323			

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F 323	Continued From page 34 *It was her expectation that chemicals were not to be commingled with resident's personal care items and could pose a serious hazard to residents. Review of the provider's 2010 policy Storage of Chemicals and Biologicals revealed: *No mention of how staff were to ensure the safety of the residents in the presence of unmonitored biohazardous laboratory specimens awaiting pickup at the nurses station. *No mention of the storing or commingling of hazardous chemicals with resident's personal care items.	F 323			
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on record review, interview, and policy review, the provider failed to ensure a sixty-day physician's visit had been completed for 3 of 21 sampled residents (3, 14, and 20). Findings include: 1. Review of resident 20's complete medical record revealed a physician's assessment had	F 387	F387 1.Residents #3, 14 & 20 have had a Dr. visit since the time of the survey. 2. All residents are potentially at risk. 3. a. Education to be sent to all attending physicians on timeliness of physician visits as well as providing education on timely physician visits to the professional nursing staff to be completed by the DON or designee on or before 6/20/14. b. Director of Nursing or designee will complete written audits weekly x 4, then monthly x 2 on timely physician visits. Sample selection will be four random residents. 4. DON or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	6/20/14	

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F 387	<p>Continued From page 35</p> <p>been completed on 1/23/14. There had been no further documentation of a physician's assessment.</p> <p>Interview on 5/7/14 at 9:40 a.m. with registered nurse (RN) south/east unit manager H revealed: *Resident 20 had not been seen by her physician for a sixty-day assessment. *The physician had not been in the facility since 1/24/14. *She agreed the physician assessments should have been done every sixty days. Surveyor: 32355</p> <p>2. Review of resident 3's complete medical record revealed a physician's assessment had been completed on 1/23/14. There had been no further physician's assessments found in her chart as of 5/7/14.</p> <p>Interview on 5/7/14 at 10:05 a.m. with the assistant director of nursing and the director of nursing revealed: *The physician had not done a sixty day visit since 1/23/14. *The physician had been contacted by the provider to remind him of the sixty day visit. *This particular physician had a history of being late for his sixty day visits. *The pharmacy consultation reports would have remained in the chart for physician review until the next sixty day visit.</p> <p>Review of resident 3's pharmacy consultation reports from 10/14/13 through 4/3/14 revealed: *The pharmacist had made a recommendation for resident 3 to have blood work on 3/6/14. *There had been no physician response or signature on the consultation report.</p>	F 387			

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F 387	Continued From page 36 Surveyor: 33265 3. Review of resident 14's complete medical record revealed: *There was no documentation of an assessment by his primary physician for greater than sixty days during the following two time periods: -8/8/13 to 11/20/13 (seventy-three days). -11/20/13 to 2/19/14 (ninety-one days). Review of the provider's August 2013 Physician Services policy revealed "Physician's visits, frequency of visits, emergency care of residents, ect. are provided in accordance with current OBRA (Omnibus Budget Reconciliation Act) regulations and facility policy." The provider could not provide any further policies regarding physician services.	F 387		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441	F441 1. Resident #3 & #4 cited during the survey is unable to be corrected as cited in the survey. 2. All residents are potentially at risk. 3. a. Education to all staff to be completed by the DON or designee on or before 6/20/14 to include: 1. Proper infection control practices to include hand washing during a dressing change. 2. Proper technique for cutting interdry fabric for dressing changes. 3. Resident care items to not be stored underneath sinks. 4. Cleanliness of lifts. 5. No staff personal items to be stored in the medication carts. 6. Medication cart cleanliness. 7. Proper cleansing of the Glucose monitor per manufacturer guidelines. 8. Proper cleansing of the whirlpool tubs per manufacturers directions. 9. Proper storage of linens in the bathing rooms.	6/20/14

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F 441	<p>Continued From page 37</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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 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: 32355 Surveyor: 33488 Based on observation, interview, and policy review, the provider failed to: *Ensure proper technique and hand washing had been performed by three of three observed registered nurses (RN) (E, F, and L) before, during, and after a dressing change for two of two observed residents (3 and 4). *Ensure the cleanliness of two of three medication carts (central wing). *Ensure personal items of staff and residents had not been stored within medication carts in one of three medication carts (central wing). *Ensure glucose meters were properly cleaned according to manufacturer's guidelines for the disinfectant used for one of one glucometer used.</p>	F 441	<p>b. Director of Nursing or designee will complete 4 random audits weekly x 4, then monthly x 2 on proper infection control procedures. Audits will include the following. 1. Proper infection control practices to include handwashing during a dressing change. 2. Proper technique for cutting interdry fabric for dressing changes. 3. Resident care items to not be stored underneath sinks. 4. Cleanliness of lifts. 5. No staff personal items to be stored in the medication carts. 6. Medication cart cleanliness. 7. Proper cleansing of the Glucose monitor per manufacturer guidelines. 8. Proper cleansing of the whirlpool tubs per manufacturers directions. 9. Proper storage of linens in the bathing rooms.</p> <p>4. DON or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.</p>		

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F 441	<p>Continued From page 38</p> <p>*Ensure Insta Dry treatment fabrics (a fabric used to wick away moisture from skin) were free from contamination for one of one residents using Insta Dry.</p> <p>*Use standard precautions (glove use by staff) during whirlpool tub disinfecting and cleaning for two of two observed whirlpool cleanings performed by certified nursing assistants (CNA) G and N.</p> <p>*Ensure manufacturer's guidelines had been followed for the cleaning and disinfecting materials used to clean one of two whirlpools (east hall).</p> <p>*Store linens free from contamination for all three bathing rooms.</p> <p>*Ensure resident's items were not stored underneath sinks for one of one nurse handwash station (west hall) and one of three (east hall) clean utility rooms.</p> <p>*Ensure EZ stand lifts were clean and free from dirt and debris for two of two randomly observed EZ stand lifts.</p> <p>Findings include:</p> <p>Surveyor: 32355</p> <p>1. Observation on 5/6/14 at 10:15 a.m. with RN C during a dressing change for resident 3 revealed:</p> <p>*She had gathered all of the necessary supplies and placed them directly on the resident's wheelchair (w/c) cushion without a barrier between them. One of the supplies had been a large package of gauze 4x (by) 4 sponges used for all residents in the facility.</p> <p>*She had retrieved a pair of gloves off the resident's w/c cushion and put them on. With those gloves she had:</p> <ul style="list-style-type: none"> -Removed the old dressing from the resident's bottom. -Retrieved several gauze 4x4 sponges from the 	F 441		

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F 441	<p>Continued From page 39</p> <p>large package and poured sterile water over them.</p> <ul style="list-style-type: none"> -Wiped around the inside and outside perimeter of the pressure ulcer. -Retrieved an ointment from inside a plastic bag lying directly on the resident's w/c cushion. -Placed some of the ointment on her fingers and applied it to the pressure ulcer. -Discarded her gloves. <p>*She had placed the large package of gauze 4x4 sponges back in the medication cart on top of other treatment supplies to be used for other residents in the facility.</p> <p>Interview on 5/7/14 at 10:10 a.m. with the DON revealed:</p> <ul style="list-style-type: none"> *There should have been an appropriate barrier used for the dressing supplies to be placed on. *She would have expected the RN to perform hand hygiene after changing gloves between dirty to clean dressing changes. *The gauze sponges should have been removed from the package prior to the dressing change. *There had been potential for cross-contamination due to the unsanitary procedure that was used. <p>Surveyor: 29354</p> <p>2. Observation on 5/6/14 from 10:15 a.m. through 10:30 a.m. with RN E and RN F during a dressing change to resident 4's left gluteal fold (prominent fold on the back of the upper thigh from the lower limit of the buttock) revealed:</p> <ul style="list-style-type: none"> *RN E put on a pair of gloves. She then: -Removed the old dressing to the left gluteal fold pressure ulcer. -Changed her gloves. -Took several 3x3 gauze sponges and poured 	F 441			

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F 441	<p>Continued From page 40 sterile water over them. -Took the gauze sponges and wiped around the inside and outside perimeter of the pressure ulcer. -Discarded the 3x3 sponges into the garbage can and with her same gloved hands took several gauze sponges from the package repeating the above procedure several times. -With the same pair of gloves she cut a piece of dressing, placed it into the wound, and covered the border with a foam covering. -Discarded the gloves.</p> <p>3. Observation on 5/6/14 from 10:15 a.m. through 10:30 a.m. with RN E and RN F following a dressing change to resident 4's right gluteal fold revealed: *The resident had an incontinent bowel movement (BM). *With the same pair of gloves that were used for the above dressing change RN E cleaned the BM off of the resident. She discarded the gloves and without performing hand hygiene put on a new pair of gloves. -She then placed the water container, Kleenex, TV remote, and phone on the resident's bed table. -Cleaned the scissors with an alcohol pad and placed the scissors into the closet. -Discarded the gloves.</p> <p>Interview on 5/7/14 at 2:45 p.m. with the DON revealed her expectations were to have performed hand hygiene after changing gloves between dirty to clean dressing changes.</p> <p>Review of the provider's July 2013 Handwashing policy revealed: **A minimum of ten to fifteen second</p>	F 441			

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F 441	<p>Continued From page 41</p> <p>handwashing (longer if necessary) must be performed under the following conditions: -After handling used dressings. -After handling items potentially contaminated with a resident's blood, body fluids, excretions, or secretions. -After removing gloves."</p> <p>4. Observation and interview on 5/7/14 at 8:30 a.m. with certified nurse aide (CNA) G regarding cleaning of the whirlpool tub in the east hallway revealed she: *Filled the whirlpool tub with water and disinfectant solution. *Ran the water jets for one minute. *Confirmed the water jets needed to be run for one minute. *Confirmed the whirlpool cleaning procedure listed on the bathroom bulletin board stated to run the water jets for ten minutes.</p> <p>Interview on 5/7/14 at 2:45 p.m. with the DON revealed her expectations were to run the water jets for ten minutes per the provider's policy.</p> <p>Review of the provider's undated How to Clean Cascade Tubs policy revealed: *Turn on air bubbles. *Keep running for ten minutes.</p> <p>Surveyor: 33265</p> <p>2. Observation on 5/7/14 of two medication (med) carts on the center wing revealed: *At 8:40 a.m. the medication/treatment cart being utilized by licensed practical nurse (LPN) M had a dark sticky residue with items stuck to the bottom of the drawers in: -The bottom of the top drawer on the left side of</p>	F 441			

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F 441	<p>Continued From page 42</p> <p>the cart.</p> <ul style="list-style-type: none"> -The bottom of the lowest drawer on the left side of the cart. -The bottom of second drawer down on the right side of cart. <p>*At 9:37 a.m. the medication cart being utilized by med aide O had a dark dried residue on the bottom of the top right drawer and the lowest right drawer.</p> <p>Interview on 5/7/14 at 3:30 p.m. with the DON revealed there had not been a cleaning schedule for medication carts.</p> <p>3. Observation on 5/7/13 at 8:40 a.m. of the medication/treatment cart being utilized by LPN M on the center wing revealed:</p> <ul style="list-style-type: none"> *There had been personal items not belonging to the residents in the top two drawers on the left side of the cart. *Those items had been stored with residents' care items. *Those items were identified by LPN M as being her personal items. *Those items were: <ul style="list-style-type: none"> -Eyeglasses. -A key ring with multiple keys. -A closed cloth case with unknown contents. <p>Interview on 5/7/14 at 3:30 p.m. with the DON revealed lockers had been available for staffs' personal items.</p> <p>4. Observation on 5/7/14 at 8:40 a.m. of the medication/treatment cart being utilized by LPN M on the center wing revealed there were residents' personal belongings located in with resident care items in the double-locked area in the bottom right drawer. Those included:</p>	F 441		

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F 441	<p>Continued From page 43</p> <p>*Blank checks in the checkbook of resident 19. *Plastic cup containing numerous rings covered with tape identified as having belonged to resident 31.</p> <p>Interview on 5/7/14 at 3:30 p.m. with the DON revealed residents' personal items should have been stored in the business office.</p> <p>5. Observation on 5/6/14 at 11:05 a.m., 11:10 a.m., and 11:15 a.m. on the center wing revealed RN L wiped off the outside of the glucose meter with the Micro Kill Plus. She immediately placed the glucometer in the med cart drawer it was retrieved from. Review of the manufacturer's recommendations stated the surface needed to remain wet with the Micro Kill Plus disinfectant for two minutes.</p> <p>Interview on 5/7/14 at 3:30 p.m. with the DON revealed the staff had been trained on use of the Micro Kill Plus disinfectant.</p> <p>6. Observation on 5/6/14 at 12:48 p.m. on the center wing revealed RN L cut Insta Dry fabric (fabric to draw moisture away from the skin) on the top of the medication cart without a barrier being in place on the top of the cart.</p> <p>Interview on 5/7/14 at 3:30 p.m. with the DON revealed staff should have placed a barrier down to prevent the fabric from picking up any infectious agents on the top of the med cart before cutting Insta Dry fabric.</p> <p>Surveyor: 33488</p>	F 441		

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F 441	<p>Continued From page 44</p> <p>10. Observation and interview on 5/6/14 from 4:05 p.m. through 5:00 p.m. with the maintenance supervisor and again that same day at 6:10 p.m. with the administrator regarding linens stored uncovered in the three bathing rooms revealed: *Clean washcloths and towels were stored on top of cabinets or on shelving uncovered near the whirlpool tubs (photos 6 and 7). *They agreed water, debris, particles in the air, and contamination by staff through unclean touch could easily have contaminated the linen and potentially spread germs. *They agreed the linen needed to be covered to prevent contamination.</p> <p>11. Observation and interview during the above timeframe with the maintenance supervisor of the west hall's nurse hand washing station and in the east hall clean utility room revealed: *A resident couch decorative pillow had been stuffed under the sink between the sink and pipe in the nurses hand washing station in the west hall. At the bottom of the cabinet laid a resident mattress pad full of dirt, debris, and small black mold spots. *He was unaware of the above pillow and pad. The pad had "likely been placed under the sink to catch water from condensation of the water pipe." *He agreed it could have been a potential infection issue of a moldy surface as black mold spots were on the pad. *A red plastic tub with an unidentified plastic container and an aluminum roasting pan had been placed on the mattress pad under the sink in the east clean utility room(photos 1 and 2). *He had been unaware anything had been stored under the sink, and it also had "likely been placed under the sink to catch water from condensation of the water pipe."</p>	F 441			

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F 441	<p>Continued From page 45</p> <p>*He was unsure what the unidentified white plastic container was.</p> <p>*He was unsure why an aluminum roasting pan had been placed under the sink.</p> <p>*He agreed it could have been a potential infection concern of a moldy surface as small black mold spots were on the pad and potential for standing water in the red tub had there been a leak from the pipe.</p> <p>12. Random observations on 5/6/14 and 5/7/14 from 7:30 a.m. through 6:00 p.m. of two EZ stand lifts revealed:</p> <p>*Dirt and unknown debris on the EZ stand lifts (photos 3 and 8).</p> <p>*The lifts had been used for resident care throughout the two days.</p> <p>13. Observation and interview on 5/7/14 at 7:50 p.m. with CNA N who performed the task of whirlpool cleaning and disinfecting of the whirlpool in the west hall bathing room revealed:</p> <p>*She had not donned gloves before handling the whirlpool seatbelt and chair used by the residents or the brush used to scrub the whirlpool tub.</p> <p>*She agreed she should have followed standard precautions with glove use to prevent contamination.</p> <p>*She agreed she should have washed her hands before and after cleaning and prior to donning gloves.</p> <p>14. The provider had no policy or procedure for EZ stand lift cleaning when asked for by this surveyor.</p> <p>The provider's undated infection control: Surveillance of Infection's policy revealed no information on the proper storage of resident's</p>	F 441		

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

PRINTED: 06/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/07/2014
NAME OF PROVIDER OR SUPPLIER FIRESTEEL HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST 7TH AVENUE MITCHELL, SD 57301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 46 items to ensure they were free from contamination.	F 441			

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

ORIGINAL

PRINTED: 05/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/06/2014
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NAME OF PROVIDER OR SUPPLIER FIRESTEEL HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST 7TH AVENUE MITCHELL, SD 57301
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(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
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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/06/14. Firesteel Healthcare Community was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K029 and K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain proper separation one of one hazardous areas (commercial kitchen). Openings around five sprinkler pipe penetrations and one	K 029	K29 1. No residents cited in the deficiency. 2. All residents are potentially at risk. 3. a. Education to be provided to all maintenance staff on proper separation procedures by Administrator or designee by 06/20/2014. b. Administrator or designee will complete written audits weekly x 4, then monthly x 2 on proper separation procedures. 4. Administrator or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	6/20/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carey Deaver</i>	TITLE <i>Administrator</i>	(X6) DATE <i>6/20/14</i>
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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 required for continued program participation.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/06/2014
NAME OF PROVIDER OR SUPPLIER FIRESTEEL HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST 7TH AVENUE MITCHELL, SD 57301		
(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	
K 029	Continued From page 1 flexible conduit in the ceiling were not sealed with an appropriate firestop material. Findings include: 1. Observation at 1:30 p.m. on 5/06/14 revealed the commercial kitchen had unsealed openings around five penetrations of the ceiling from two inch diameter sprinkler pipes and one opening around a flexible conduit penetration. The openings were not firestopped with an approved material. Interview with the maintenance supervisor at the time of the observation confirmed those findings.	K 029			
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain unobstructed space adjacent to the sprinkler deflector so the water discharge was not interrupted in one randomly observed resident's room (206). Findings Include: 1. Observation at 2:30 p.m. on 5/06/14 revealed a single sprinkler in the ceiling of resident room 206. The room was a double occupancy room with two privacy curtains. The sprinkler discharge pattern would have to penetrate both curtains if closed at the same time. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he	K 062	K62 1. No residents cited in the deficiency. 2. All residents are potentially at risk. 3. a. Education to be provided to all maintenance staff on proper sprinkler deflection standards by Administrator or designee by 06/20/2014. b. Administrator or designee will complete written audits weekly x 4, then monthly x 2 on proper sprinkler deflection standards. 4. Administrator or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	6/20/14	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/06/2014
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NAME OF PROVIDER OR SUPPLIER FIRESTEEL HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST 7TH AVENUE MITCHELL, SD 57301
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(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
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K 062	Continued From page 2 was unaware of the second curtain's possible interruption of the sprinkler discharge pattern.	K 062		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 05/15/2014
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 05/06/2014
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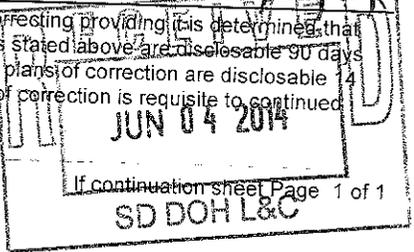
NAME OF PROVIDER OR SUPPLIER FIRESTEEL HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST 7TH AVENUE MITCHELL, SD 57301
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/06/14. Firesteel Healthcare Community (Building 02) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carey Brewer</i>	TITLE <i>Administrator</i>	(X6) DATE <i>6/2/14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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 180 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.



 JUN 04 2014
 SD DOH L&C
 If continuation sheet Page 1 of 1

ORIGINAL

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10653	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2014
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NAME OF PROVIDER OR SUPPLIER FIRESTEEL HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST 7TH AVENUE MITCHELL, SD 57301
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(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) COMPLETE DATE
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S 000	Initial Comments Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 5/05/14 through 5/07/14. Firesteel Healthcare Community was found not in compliance with the following requirement: S280.	S 000	Addendums noted with an asterisk per 6/20/14 telephone to facility administrator & DON. JK/SDD/ME	
S 280	44:04:06:04 NURSING POLICIES AND PROCEDURES Policies and procedures that provide the nursing staff with methods of meeting its administrative and technical responsibilities in providing care to...residents must be established and maintained. The policies must include at least the following: (1) The noting of diagnostic and therapeutic orders; (2) Assigning the nursing care of...residents; (3) Administration and control of medications; (4) Charting by nursing personnel; (5) Infection control; (6) ...resident safety; and (7) Delineation of orders from nonphysician practitioners. This Rule is not met as evidenced by: Surveyor: 34030 Preceptor: 29354 Based on interview and record review, the provider failed to ensure annual medication (med) aide training was completed for all trained unlicensed assistive personnel (UAP). Findings include: 1. Interview on 5/6/14 at 3:10 p.m. with certified	S 280	S280 1. No residents cited in the deficiency. 2. All residents are potentially at risk. 3. *Med aide training was completed 6/20/14. JK/SDD/ME a. Education to training and education staff to be completed by the DON or designee on or before 6/20/14 on proper annual med aide training requirements.* b. Director of Nursing or designee will complete written audits weekly x 4, then monthly x 2 on proper annual med aide training requirements. 4. DON or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3. 1. The noting of diagnostic & therapeutic orders 2. assigning the nursing care of residents 3. administration & control of medications 4. charting by nursing personnel 5. infection control & resident safety 7. delineation of orders from nonphysician practitioners. JK/SDD/ME	6/20/14

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

Carey Beaman

TITLE

Administrator

(X6) DATE

STATE FORM

021199

FO5111

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If continuation sheet 1 of 2

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10653	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2014
NAME OF PROVIDER OR SUPPLIER FIRESTEEL HEALTHCARE COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST 7TH AVENUE MITCHELL, SD 57301		
(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) COMPLETE DATE
S 280	Continued From Page 1 nursing assistant (CNA) K revealed she: *Had worked at the facility as a med aide for three years. *Had not received any additional med aide training. Interview and record review on 5/7/14 at 8:55 a.m. with registered nurse J revealed: *CNA/UAP K had completed one med aide competency review in 2013 but no other since having been hired. *She had done random med aide competency reviews with the med aides but no annual training. *She agreed annual med aide training should have been done. Interview and record review on 5/7/14 at 2:30 p.m. with the director of nursing revealed: *CNA/UAP K had a hire date of 5/21/09 and completed med aide certification on 8/11/10. *There was no med aide training policy. *She had not been aware it was a requirement. *She agreed annual med aide training should have been done.	S 280	*The education policy will be completed 6/10/14. JK/SD0041MF	