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

ORIGINAL

PRINTED: 09/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	43A038		09/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHILIP NURSING HOME	503 WEST PINE POST OFFICE BOX 790 PHILIP, SD 57567

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 29162 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/8/14 through 9/10/14. Phillip Nursing Home was found not in compliance with the following requirements: F170, F248, F280, F281, F323, F371, F431, and F441.	F 000	Addendums noted with an asterisk per 10/6/14 telephone to facility administrator. KG/SDDOH/MF	
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on interview, the provider failed to ensure Saturday delivery of mail for all residents. Findings include: 1. Group interview on 9/9/14 at 1:30 p.m. with seven randomly selected residents confirmed they had not received their mail on Saturdays. Interview on 9/10/14 at 8:30 a.m. with the social services designee confirmed the activity person was responsible for the delivery of mail to the residents. Interview on 9/10/14 at 8:50 a.m. with the activity director revealed the activity department was responsible for resident mail delivery. They had not delivered mail to the residents on Saturday,	F 170	F170 Mail delivery for all residents will be conducted Mon – Sat. by Activities staff. A policy has been written and implemented by the DON/CNO effective 9/15/14. The activities coordinator or designee will QI mail delivery every Saturday for one month, then monthly and report findings to QA committee [redacted] quarterly, or until corrected. KG/SDDOH/MF	10/30/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kent Olson | TITLE: CEO/Administrator | (X6) DATE: 10/3/14

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

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F 170	Continued From page 1 because there was no one in the business office at the hospital. The office had been locked, and she had not had a key to that office. Interview on 9/10/14 at 1:30 p.m. with the chief nursing officer (CNO) confirmed she had not known the residents had not been receiving their mail on Saturdays. A policy for resident mail delivery had been requested. On 9/10/14 at 1:30 p.m. the CNO stated there was not a policy for delivery of resident mail.	F 170		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, interview, and record review, the provider failed to ensure nine of nine sampled residents (1, 2, 3, 4, 5, 6, 7, 8, and 9) had individualized activities provided to meet their needs. Findings include: 1. Random observations on 9/8/14 from 2:30 p.m. through 9/10/14 until 1:00 p.m. revealed resident 2 had rested in bed a good portion of the day. She had attended meals. She had not been observed participating in a planned/organized activity.	F 248	F248 Directed In-service training conducted on October 2nd which included review of deficiencies and what constitutes an activity for pleasure and an ADL. Activities Coordinator and activities staff instructed to review and revise activity policies and conduct focus activity assessments to determine individual activities that residents 1, 2, 3, 4, 5, 6, 7, 8, and 9 and all other residents enjoy. Revise residents 1,2,3,4,5,7,8, and 9 and all other resident's Activity Care Plans and Activity logs based upon their focused assessment to best reflect their cont.	10/30/14

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F 248	Continued From page 2 Review of her revised 6/11/14 care plan revealed no focus areas that had addressed activities. Review of resident 2's revised 9/8/14 Additional Activities Care Plan Ideas form revealed two problems had been identified. *The first problem had stated the resident had been dependent on staff related to a long list of mental and physical ailments. -Those ailments had included dementia (memory problems), and depression. *The second problem identified stated the resident had little to no activity involvement due to dementia and "debility psychosis." -The interventions listed with those problems had very few individualized options. -Reading had been listed but had not identified what the resident had preferred to have read to her. -Being outside had been listed but had not stated what she would have wanted to do outside. Review of resident 2's Activity attendance/participation logs for the months of July, August, and September 2014 revealed: *She had walked in the hall almost everyday. *Staff had visited every day. *The log had not identified what staff had visited or the topic. *She had been off the unit every day. *It had not stated where the resident had gone or what she had done when she had been off of the unit. *She had participated in music therapy every day. *She had listened to the "News and Weather"every day. *No individualized activities had been identified on the attendance log form.	F 248	individual needs. Activities Coordinator or designee to audit four resident care plans and activity logs once weekly for one month than once monthly for 5 months or until corrected. Findings to be reported to QA committee by Activities Coordinator quarterly. 1. Resident 2 and all residents will have a focused assessment for individual activities that meet her needs related to her medical problems. Resident 2 and all resident's Activity Logs will be reviewed and amended to reflect her individual activities of pleasure and not document ADL's and normal daily routines. 2. Resident 3 and all resident's Activity Care plans will be reviewed and revised to reflect their current level of participation related to their medical limitations. Resident 3 and all resident's Additional Activities Care Plan Ideas form will be reviewed and revised to indicate individualized needs. Interventions will reflect individualized needs and specific activities that she enjoys to participate in. Resident 3 and all resident Activity logs will be reviewed and revised to reflect those activities that each resident con't	

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F 248	Continued From page 3 2. Review of resident 3's revised 8/21/14 care plan revealed: *The resident had limited physical mobility related to deconditioning and non-healing fractures of an arm and hip. *The resident had impaired cognitive function and impaired thought processes (poor mental reasoning ability) related to dementia. *The resident had depression related to her dementia and the aging process. Activity related interventions listed with those focus areas had been: *Invite the resident to activity programs that had encouraged her to come out of her room. *Have one-to-one activities for her. *Those activities were the only ones she had enjoyed. *Reminisce with the resident using photos of her family and friends. *Assist the resident to develop a program of activities that was meaningful and of interest to her. *Offer those activities to her. *Encourage and offer opportunities for exercise and physical activity. Review of her revised 8/18/14 Additional Activities Care Plan Ideas forms revealed three problems had been identified: *The first problem had stated the resident was withdrawn from activities of interest and had reduced social interactions. -That had been evidenced by her refusal to go to activities even when offered to take her to activities in her bed. -The goal had been the resident would talk about herself in a positive way. -The individualized interventions had been:	F 248	specifically enjoys to participate in and not document participation on their ADL's or daily routines. 3. Resident 9 and all resident Activity Care plans will be reviewed and revised to address focused activity areas as determined by assessment completed by Activities Coordinator or designee. Resident 9 and all resident activity interventions will be reviewed and revised to reflect individual needs. Resident 9 and all resident activity goals will be reviewed and revised to reflect individualized needs. 4. Informed and instructed Activities Coordinator that some of the activities listed did not constitute an activity of pleasure, but is considered part of a resident's daily routine or ADL. Such as: Ambulating independently in the hall Room curtains being open daily A resident leaving their rooms for meals, a bath or care Staff visiting with residents during personal care Music being played daily in the lobby con't.	

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F 248	Continued From page 4 --Encourage to take an active role in devotions, novel reading, and poetry. --It had not stated who was to have involved her in those activities or where and when it would occur. --One-to-one visits with any staff on a daily basis. --It had not stated what the one-to-one visits would include. --Attend an activity at least once a week. --Be up in the wheelchair at least once a week. *The second problem had been the resident had been dependent on staff for activities, cognitive stimulation, and social interaction. -That had been due to a long list of medical diagnosis to include a wound, infection, depression, and dementia. -The goals had been the resident would: --Participate in an activity of choice one time per week. --Maintain involvement in cognitive stimulation and social activities as desired. --The interventions listed had not been individualized and had not listed any specific activity the resident would be interested in. *The third problem had been little to no activity involvement related to her wound, infection, being bed-ridden and side-effects of her anti-psychotic medications. -The goals had been the resident would: --Express satisfaction with the activities offered. --She would participate in an activity of choice one time per week. --The interventions listed had not been individualized and had not listed any specific activity the resident would be interested in. Review of resident 3's Activity logs for the months of July, August, and September 2014 revealed: *Staff had visited every day.	F 248	TV being turned on in the dining room daily during meals These items will be taken off the Activity log and not be documented as an organized activity. Activity Log will be reviewed and revised to reflect activities of pleasure and enjoyment not to include ADL'S or daily routines. Activity Coordinator or designee will audit four logs weekly then monthly for 5 months or until corrected and report findings to QA committee quarterly. 5. Resident 5 and all resident care plans will be reviewed and revised to address focused activity areas as determined by assessment completed by Activity Coordinator or designee. Resident 5 and all resident's Activity Flow sheet will be reviewed and revised to reflect resident's individualized needs based on their physical and medical limitations. 6. Resident 6 and all resident care plans will be reviewed and revised to address focused activity areas as determined by assessment completed by Activities Coordinator or designee. Resident 6 and all resident Activity flow sheets will be cont.	

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F 248	Continued From page 5 *She had been off the unit one time during those months. *She had participated in music therapy eight times during those months. *She had listened to the "News and Weather" eight times during those months. *The resident had birdwatching marked twenty-eight days in July. *The resident had "looks out the window" every day but one in August and every day but one in September. *She had one-to-one visits marked five times during those months. *Had a pacemaker check listed as an activity on 7/29/14 (that had been her off the unit activity). 3. Review of resident 9's 7/1/14 care plan revealed no focus areas that had addressed activities. Review of her 7/2/14 Additional Activities Care Plan Ideas form revealed three problems had been identified: *The first problem had stated the resident had been dependent on staff for activities due to a seizure disorder, a cerebral vascular accident (CVA) (stroke) with right sided weakness, elevated cholesterol level, and depression. -The goals had been the resident would: --Attend at least one to two activities a week and maintain cognitive stimulation. --Maintain involvement in cognitive stimulation and social activities as desired. --The interventions listed had not been individualized and had not listed any specific activity the resident would be interested in. *The second problem stated the resident was indifferent to social interactions and had spent less than a third of her time involved in activities.	F 248	reviewed and revised to reflect actual activities which occurred daily. 7. Resident 1 and all resident care plans will be reviewed and revised to address focused activity areas as determined by assessment completed by Activities Coordinator or designee. 8. Resident 4 and all resident care plans will be reviewed and revised to address focused activity areas as determined by assessment completed by Activities Coordinator or designee. Resident 4 and all resident Activity flow sheets will be reviewed and revised to reflect participation in activities of pleasure and not daily routines or ADL's. 9. Resident 7 and all resident care plans will be reviewed and revised to address focused activity areas as determined by assessment completed by Activity Coordinator or designee. Resident 7 and all resident Activity flow sheets will be reviewed and revised to reflect participation in activities of pleasure and not daily routines or ADL's. 10. Resident 8 and all resident's care plans will be reviewed and revised to address focused activity areas as	

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F 248	Continued From page 6 -The goals for this problem had been the resident would: --Again attend at least one to two activities a week. --Be encouraged to attend group activities. --Again the interventions had not been individualized and had not listed any specific activity the resident would be interested in. *The third problem stated the resident had little to no activity involvement related to side effects of the anti-seizure medication. -The goals for this problem had been the resident would: --Express satisfaction with the activities offered to her. --Would attend activities one to two times per week. --Be assisted to activities of her choice. --Be allowed to sleep when she had wanted to do so. --Again the interventions had not been individualized and had not listed any specific activity the resident would be interested in. 4. Interview on 9/10/14 at 10:30 a.m. with the activity coordinator regarding resident 2 and 3 had confirmed: *When resident 2 had walked in the hallway that had meant she of her own choice had ambulated up and down the hallways. *She had described this walking as "wandering." *Resident 2 would stop and sit on her wheeled walker when she had become tired. *It had not been an organized, staff directed activity. *When resident 3 "bird watched" it meant the curtains had been open and she could see outside. *When resident 3 had "looked out the window"	F 248	determined by assessment completed by Activity Coordinator or designee. Resident 8 and all resident Activity flow sheets will be reviewed and revised to reflect participation in activities of pleasure and not daily routines and ADL's. Activities Coordinator and/or designee will audit four resident Activity Care plans and Activity flow sheets/logs weekly for focused activity areas and individualization for one month than monthly for 5 months or until corrected. Findings of audits will be reported to QA meetings quarterly by Activities Coordinator. CNO and Activity Coordinator have reviewed and implemented an Activity policy and One- to- one activity policy. These policies were reviewed with all care staff at directed in-service on Oct. 2nd. 10/30/14 [redacted] KE/SDCH/MF	

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F 248	Continued From page 7 that had meant the curtains were open. *When a resident had been off the unit that frequently meant the resident had left their room for meals, a bath, or some type of care. *Staff visitation had meant staff visited with the resident while they had performed care. *No topics were listed for the staff to use during those visits while providing basic care. *The care had included assisting the resident to the bathroom, eating, and dressing. *Music therapy had meant the resident was present in the hallway when music was played in the lobby area. *"News and Weather" had meant the resident had been present in the dining room when the television had been on a station with the weather and news being reported. *Staff had not ensured the residents had been engaged in those activities, discussed them, or related them to the residents at that time. Surveyor: 29162 5. Observations of resident 5 throughout the survey from 2:30 p.m. on 9/8/14 through 1:00 p.m. on 9/10/14 revealed she attended all meals and napped in the afternoon. She had not been observed attending an organized activity. Review of her revised 9/4/14 care plan revealed no focus areas that had addressed activities. Review of her Additional Activities Care Plan revealed three problem areas with possible goals and possible approaches identified. Those areas had been:	F 248		

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F 248	Continued From page 8 *Decreased activity level related to Alzheimer's dementia and falls. -Involve in activities two to four times a week. -Give activity calendar to resident, discuss it with her, inform her of activities, and allow her to make choices. -- Her last mini-mental examination on 8/4/14 indicated she rarely or never made herself understood. -Bring resident to meals or hallway. -Inform and invite resident to music. --The resident had not been observed listening to music in her room or the entry way during the survey. -One-on-one visits by activity staff fifteen minutes per day. --The resident had not had one-on-one activities during the survey. *Dependent of staff for activities, cognitive stimulation, and social interactions. -To attend most meals in dining room for socialization. -One-on-one to include but not limited to lotion therapy, massage, visiting, and being read to. --This activity had not occured. *Little or no activity involvement. -At risk for side effect of mood altering drug. She often hollered or called out and was disruptive in activities. --Side effect of mood altering drug had no relation to an individual activity care plan. Review of resident 5's Activity flow sheet for August 2014 revealed: *Music therapy, news, and weather were checked as a passive participant for thirty of thirty-one days. *Visits off the unit and staff visits were checked as having occurred thirty of thirty-one days in	F 248		

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F 248	Continued From page 9 August 2014. *One-to-one visits had occurred only four times in August 2014. 6. Observations of resident 6 throughout the survey from 2:30 p.m. on 9/8/14 through 1:00 p.m. on 9/10/14 revealed she attended all meals and rested in bed in the morning and afternoon. She had not been observed attending an organized activity. Review of her revised 9/4/14 care plan revealed no focus areas that had addressed activities. Review of her current Additional Activities Care Plan revealed two problem areas with possible goals and possible approaches identified. Those had been: *Dependent on staff for activities, cognitive stimulation, and social interactions. -Will attend most meals in the dining room. -One-on-ones to include but not limited to lotion therapy and massage. -Staff visiting with resident during cares. -Resident to be in hallway. *Little or no activity involvement due to advanced Alzheimer's dementia. -Involve family in activities and encourage visits and participation. --Family ass not responsible for the resident's activity care plan. Review of resident 6's Activity flow sheet for August 2014 revealed: *Music therapy, news, and weather were checked as a passive participant for thirty of thirty-one days. *Visits off the unit and staff visits were checked as having occurred thirty of thirty-one days in	F 248		

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F 248	Continued From page 10 August. *One-to-one visits had occurred only seven times in August 2014. Interview on 9/10/14 at 11:15 a.m. with the activity director revealed: *She had considered: -Family visits part of the resident's individual activity care plan. -Staff visits at the time of personal care an individualized activity. -The television turned on in the dining room for the weather and news an individualized activity. -Music in the entry way and residents wheeling their wheelchairs in the hallway an individualized activity. *Lotion therapy and reading to the resident had been the only one-on-one activities she did with the residents. *She tried to complete all one-to-one activities at least weekly but that had not always occurred. Surveyor: 32572 7. Observations of resident 1 throughout the survey from 2:30 p.m. on 9/8/14 through 1:00 p.m. on 9/10/14 revealed she attended all meals and napped in the afternoon. She had not been observed attending an organized activity. Review of her revised 6/17/14 care plan revealed no focus areas that had addressed activities. Review of her 6/19/14 Additional Activities Care Plan revealed two problem areas with possible goals and possible approaches identified. Those had been: *Problem area of "Dependent on staff for	F 248		

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F 248	Continued From page 11 activities, cognitive stimulation, social interaction." -Goal had been: --"Resident to attend any activity of choice and be offered trips away from NH (nursing home)." --"Resident to be offered newspapers and magazines to read, and music when in room or lobby." --"Family to be encouraged to visit and participate in activities, 1 on 1's (one-on-ones) to include but not limited to visiting, painting fingernails reading to lotion therapy and massage." -The interventions were: --"Encourage family involvement in activity program." --"One-to-one bedside/in room visits and activities if resident unable to attend out of room activities." --"Activities needs/interests assessment on admission to determine interests and activity needs." -"All staff to converse with resident while providing care." --"Assist with arranging community activities. Arrange transportation." --"Introduce resident to other residents or [of] similar age, background, interests." --"Invite family members to activity functions." --"Provide a program of activities that is of interest and empowers resident by encouraging/allowing choice, self-expression, and responsibility." --"Provide with materials for individual activities as desired." --"Thank resident for attendance at activity function." --"Turn on TV, music in room to provide sensory stimulation." *Another problem of "Reduced activity involvement [due to] possible side effects of antidepressants and advanced age."	F 248		

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	43A038		09/10/2014

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F 248	Continued From page 12 -Goals listed were: --"Will express satisfaction with type of activities and level of activity involvement when asked by next review date." --"Will participate in activities of choice 3-5 times weekly by review date." --"Resident to attend activities of choice but wishes not to be awakened if sleeping. Family involvement encouraged." -Interventions were: --"Assess for impact of medical problems on activity level." This line had been underlined. --"Assess prior level of activity involvement and interests by talking with resident, staff, family." --"Explain importance of social interaction, leisure activity time." --Her 6/16/14 last mental exam indicated she had severe mental impairment. --"Invite/encourage family members to attend activities with resident." --"Modify daily schedule, treatment plan PRN (as needed) to accommodate activity participation." --"Offer variety of activity types and locations." --"Offer to assist/escort resident to activity functions." --"Remind that he/she may leave activities at any time, and is not required to stay for entire activity." 8. Observations of resident 4 throughout the survey from 2:30 p.m. on 9/8/14 through 1:00 p.m. on 9/10/14 revealed she attended all meals and napped in the afternoon. She had not been observed attending an organized activity. Review of her revised 8/7/14 care plan revealed no focus areas that had addressed activities. Review of her reviewed 8/4/14 Additional Activities Care Plan revealed two problem areas	F 248		

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F 248	Continued From page 13 with possible goals, and possible approaches identified. Those had been: *"Dependent on staff for activities, cognitive stimulation, social interaction." -Goals were to: --"Will attend/participate in activities of choice 2-3 times weekly by next review." --"Will maintain involvement in cognitive stimulation, social activities as desired through review date." --"Resident to attend RT (restorative therapy) 5-7 days a week and attend activities if choice especially in the am and staff to visit and interact with resident when she can." --"She often will not answer questions due to dementia and CVA (stroke) but understands what is said and will laugh when staff or family is funny." --"Family to visit often including dog as resident likes '_____' (dog's name)." --"Resident to be offered TV especially funny shows like "I Love Lucy." -Interventions had been: --"Encourage family involvement in activity program." --"One-to-one bedside/in room visits and activities if resident unable to attend out of room activities." --"Activities needs/interests assessment on admission to determine interests and activity needs." --"All staff to converse with resident while providing care." --"Introduce resident to other residents or [of] similar age, background, interests." --"Invite family members to activity functions." --"Provide a program of activities that is of interest and empowers resident by encouraging/allowing choice, self-expression, and responsibility."	F 248		

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F 248	Continued From page 14 --"Provide with materials for individual activities as desired." --"Thank resident for attendance at activity function." --"Turn on TV, music in room to provide sensory stimulation." *Another problem of "Little or no activity involvement [due to] possible side effects of antidepressant medication." -Goals listed were: --"Will express satisfaction with type of activities and level of activity involvement when asked by next review date." --"Will participate in activities of choice 2-3 times weekly by review date." --"Resident to attend activities of choice but wishes not to be awakened if sleeping. Family involvement encouraged." -Interventions were: --"Assess for impact of medical problems on activity level." This line had been circled. --"Assess prior level of activity involvement and interests by talking with resident, staff, family." --"Explain importance of social interaction, leisure activity time." --Her 6/16/14 last mental exam indicated she had severe mental impairment. --"Invite/encourage family members to attend activities with resident including "_____" (dog's name)." --"Modify daily schedule, treatment plan PRN (as needed) to accommodate activity participation." --"Offer variety of activity types and locations." --"Offer to assist/escort resident to activity functions." --"Remind that he/she may leave activities at any time, and is not required to stay for entire activity." Review of resident 5's Activity flow sheet for	F 248		

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F 248	Continued From page 15 August 2014 revealed: *Music therapy, news, and weather were checked as a passive participant for thirty of thirty-one days. *News and weather had been checked as a passive participant for thirty of thirty-one days. *Visits off the unit and staff visits were checked as having occurred thirty of thirty-one days. *One-to-one visits had occurred only six times. 9. Observations of resident 7 throughout the survey from 2:30 p.m. on 9/8/14 through 1:00 p.m. on 9/10/14 revealed she attended all meals and napped in the afternoon. She had not been observed attending an organized activity. Review of her revised 7/31/14 care plan revealed no focus areas that had addressed activities. Review of her 7/28/14 reviewed Additional Activities Care Plan revealed two problem areas with possible goals, and possible approaches identified. Those had been: *"Dependent on staff for activities, cognitive stimulation, social interaction." -Goals were to: --"Will attend/participate in activities of choice 2-3 times weekly by next review." -"Will maintain involvement in cognitive stimulation, social activities as desired through review date." --"Resident to attend most meals in dining room and be in hallway with music to prevent social isolation." --"Resident's family to visit often." --"Resident will be taken to low level activities to include but not limited to church, devotions, music, Friday entertainment, happy hour, novel reading, and SD (South Dakota) magazine."	F 248		

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F 248	Continued From page 16 --"Resident to attend RT (restorative therapy) 5-7 days a week." --"Resident to receive low calorie snacks due to diabetes." -The interventions were: --"Encourage family involvement in activity program." --"One-to-one bedside/in room visits and activities if resident unable to attend out of room activities." --"Activities needs/interests assessment on admission to determine interests and activity needs." --"All staff to converse with resident while providing care." --"Assist with arranging community activities. Arrange transportation." --"Introduce resident to other residents or [of] similar age, background, interests." --"Invite family members to activity functions." --"Provide a program of activities that is of interest and empowers resident by encouraging/allowing choice, self-expression, and responsibility." --"Provide with materials for individual activities as desired." --"Thank resident for attendance at activity function." --"Turn on TV, music in room to provide sensory stimulation." *Another problem of "Little or no activity involvement due to side effects of mood altering drugs, advanced age, and dementia." -Goals had been: --"Will express satisfaction with type of activities and level of activity involvement when asked by next review date." --"Will participate in activities of choice 2-3 times weekly by review date." --"Be aware of residents blood sugar before	F 248		

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F 248	Continued From page 17 feeding snacks." -Interventions were: --"Assess for impact of medical problems on activity level." This line had been underlined. --"Assess prior level of activity involvement and interests by talking with resident, staff, family." --"Explain importance of social interaction, leisure activity time." --Her 6/16/14 last mental exam indicated she had severe mental impairment. --"Invite/encourage family members to attend activities with resident." --"Modify daily schedule, treatment plan PRN (as needed) to accommodate activity participation." --"Offer variety of activity types and locations." --"Offer to assist/escort resident to activity functions." --"Remind that he/she may leave activities at any time, and is not required to stay for entire activity." Review of resident 5's Activity flow sheet for August 2014 revealed: *Music therapy, news, and weather were checked as a passive participant for thirty of thirty-one days. *News and weather had been checked as a passive participant for thirty of thirty-one days. *Visits off the unit and staff visits were checked as having occurred thirty of thirty-one days. *One-to-one visits had occurred only two times. 10. Observations of resident 8 throughout the survey from 2:30 p.m. on 9/8/14 through 1:00 p.m. on 9/10/14 revealed she attended all meals and napped in the afternoon. She had not been observed attending an organized activity. Review of her revised 8/28/14 care plan revealed	F 248		

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F 248	Continued From page 18 no focus areas that had addressed activities. Review of her reviewed 8/25/14 Additional Activities Care Plan revealed three problem areas with possible goals, and possible approaches identified. Those had been: *"Dependent on staff for activities, cognitive stimulation, social interaction." -Goals were to: --"Will attend/participate in activities of choice 2-3 times weekly by next review." --"Will maintain involvement in cognitive stimulation, social activities as desired through review date." --"Resident is diabetic and must have low carb [carbohydrate] and low sugar snacks." --"She likes woodworking and needs more active activities for exercise." --"Family visits when they can." --"Resident is confused at times forgets she is diabetic." --"Will encourage to attend activities to combat depression." -The interventions were: --"Encourage family involvement in activity program." --"One-to-one bedside/in room visits and activities if resident unable to attend out of room activities." --"Activities needs/interests assessment on admission to determine interests and activity needs." --"All staff to converse with resident while providing care." --"Assist with arranging community activities. Arrange transportation." --"Introduce resident to other residents or [of] similar age, background, interests." --"Invite family members to activity functions." --"Provide a program of activities that is of	F 248		

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F 248	Continued From page 19 interest and empowers resident by encouraging/allowing choice, self-expression, and responsibility." --"Provide with materials for individual activities as desired." --"Thank resident for attendance at activity function." --"Turn on TV, music in room to provide sensory stimulation." *Another problem area had been "Emotional unwillingness to participate in activity program." -Goals of: --"Will participate in 3-5 chosen activities per week X (times) 90 days." --"Will receive daily opportunities for social contact X 90 days." --"Will receive in-room visits 2 times a week X 90 days." -Interventions listed were: --"Allow choice of activity for interaction." --"Assess interests and attempt to involve in activities 3-5 times weekly." --"Assist to explore the personal meaning of usual activity and. or favorite leisure activities." --"Assure awareness of scheduled activities." --"Determine commitment to increasing frequency and. or range of activity." --"Encourage family visitations and participation in care planning if invited by resident." --"Encourage participation in social activities." --"Escort to activity of choice." --"Explain activity program, review calendar, give tour of activity areas. Encourage participation in a activities of choice." --"Facilitate activity substitution when there are limitations in time, energy, or movement focus on what he. she can do, rather that on deficits." --"Furnish resident with own personal activity	F 248		

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F 248	Continued From page 20 calendar each month and highlight those of special interest." --"Inform of facility events on a regular basis (use short-term time frames)." --"Note which activities hold interest longest & (and) guide to attend/participate." Review of resident 8's Activity flow sheet for August 2014 revealed: *Music therapy, news, and weather were checked as a passive participant for thirty of thirty-one days. *News and weather had been checked as having occurred thirty of thirty-one days. *Visits off the unit and staff visits were checked as having occurred thirty of thirty-one days. *One-to-one visits had occurred only five times. *Look out lobby door had been checked as having occurred nine times. Interview on 9/10/14 at 11:00 with the acitivity director revealed: *When a resident left their room that had been considered an off the unit activity. *Restorative therapy had been considered an activity. *Staff visits during care had been considered an activity. *The news and weather activity had been turning on the weather channel in the dining room while residents were in the dining room. *In the hall or looby had been considered an activity. A policy for activities had been requested. On 9/10/14 at 1:30 p.m. the CNO offered some of the requested policies for the survey. No policy for activities or one-to-one activities was received by exit at 2:30 p.m. that day.	F 248		

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F 280 SS=F	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, record review, interview, and policy review, the provider failed to ensure care plans for 9 of 9 sampled residents (1, 2, 3, 4, 5, 6, 7, 8, and 9) had included assessments, problems, goals, and interventions for: *The use of grab/positioning bars while in bed. *Reflected the current status on three of nine residents. Findings include: 1a. Observation from 9/8/14 through 9/10/14 revealed residents 2, 3, and 9 had	F 280	F280 DON/CNO conducted an in-service on Oct. 2nd to instruct and educate staff how to implement and change a resident care plan to reflect resident's individual care needs. 10/30/14 A assessment for grab bar use was completed for residents 1,2,3,4,5,6,7,8, and 9 and all residents to determine need for grab bars. Grab bars were removed from 17 resident's beds after assessments completed. DON or designee will conduct grab bar assessments upon admission for all new residents and with a significant change in health status as defined in the MDS. Grab bar assessments will be reviewed each quarter during the MDS process to determine the continued need for or exclusion of grab bars for the resident(s) being assessed for the MDS. [redacted] 1a. Resident 2, 3, and 9 and all resident's care plans were reviewed and revised to either include or exclude use of grab bar(s). DON or designee will audit five care plans monthly for 6 months or until corrected and report findings to QA committee quarterly. con't.	

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F 280	Continued From page 22 grab/positioning bars on their beds. Review of residents 2, 3, and 9's care plans revealed: *Resident 2's care plan was last completed on 6/8/14. *Resident 3's care plan was last completed on 8/21/14. *Resident 9's care plan was last completed on 7/1/14. *None of the above care plans addressed the use of bed rails while those residents had been in bed. Surveyor: 29162 b.Observation from 9/8/14 through 9/10/14 revealed residents 5 and 6 had grab/positioning bars on their beds. Review of residents 5 and 6's care plans revealed: *Resident 5's care plan was last completed on 9/4//14. *Resident 6's care plan was last completed on 9/4/14. *None of the above care plans addressed the use of grab/postioning bars while those residents had been in bed. Surveyor: 32572 c. Random observations from 9/8/14 through 9/10/14 revealed residents 1, 4, 7, and 8 had grab/positioning bars on their beds. Review of residents 1, 4, 7, and 8's care plans revealed: *Resident 1's care plan had been reviewed on 6/17/14. *Resident 4's care plan had been reviewed on 8/7/14.	F 280	b. Resident 5 and 6 and all resident care plans were reviewed and revised to either include or exclude use of grab bar(s). DON or designee will audit five care plans monthly for 6 months or until corrected and report findings to QA committee quarterly. c. Resident 1, 4, 7, and 8 and all resident care plans were reviewed and revised to either include or exclude use of grab bar(s). DON or designee will audit five care plans monthly for 6 months or until corrected and report findings to QA committee quarterly. cont.	

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F 280	Continued From page 23 *Resident 7"s care plan had been reviewed on 7/31/14. *Resident 8's care plan had been reviewed on 8/28/14. *None of the above care plans addressed the use of grab/positioning bars while those residents had been in bed. Refer to F323, findings 1, 2, 3, 4, 5, 6, 7, and 8. 2a. Review of resident 1's medical record revealed: *She had been admitted on 12/16/13. *Her diagnoses had been: -Macular degeneration (decline of vision). -Hyperlipidemia (elevated fat in the blood). -Parkinson's disease (disease of the nervous system that causes shaking). -Hypertension (high blood pressure). -GERD (reflux or heart burn). -Anxiety. -Dementia (disorganized thinking). Her revised 12/23/13 care plan revealed: *Focus area of ADL (activities of daily living) deficit. *One of the interventions had been "Tabs (monitoring device)/bed alarms to be placed for resident safety and to alert staff if mobile." Random observations from 9/8/14 through 9/10/14 revealed no tabs/bed alarm on the bed, wheelchair, or walker. Focus area of GERD on the above care planrevealed: *Intervention of "Provided small frequent meals rather than three large ones." *Random observations from 9/8/14 through	F 280	2a. Resident 1's care plan has been reviewed and revised to DC tabs alarms and frequent meals to reflect current interventions. DON or designee will audit five care plans monthly for 6 months or until corrected and report findings to QA committee quarterly. con't.	

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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
F 280	Continued From page 24 9/10/14 revealed she had been provided three large meals along with snacks. b. Review of resident 4's medical record revealed: *She had been been admitted 11/23/09. *Her diagnoses had been: -Peptic ulcer (stomach ulcer). -Dementia. -Hypertension. -GERD. -Osteoporosis (decrease bone density). -Depression. -Congestive heart failure (fluid build up around the heart). -MRSA (methicillin resistant staphylococcus aureus, a hard to treat infection). Her revised 11/5/2013 care plan revealed: *Focus area of limited physical mobility. -Intervention of non-weight bearing. -Walking activities to promote mobility. Observation on 9/8/14 at 9:43 a.m. revealed she had been transferred using the EZ stand mechanical lift. During that transferring she had to bear weight on both of her lower extremities. Focus area of GERD on the above care plan revealed: *Intervention of "Provided small frequent meals rather than three large ones." *Random observations from 9/8/14 through 9/10/14 revealed she had been provided three large meals along with snacks. Focus area of potential for nutritional problems on the above care plan revealed: *Intervention of "Place at feeder table to assist	F 280	b. Resident 4's care plan has been reviewed and revised to DC walking activities. Change CP from non-weight bearing to weight bearing with EZ stand. DC "small frequent meals rather than three large ones." Change CP from extensive assist in eating to total care of staff to eat while sitting at the assist-to-feed table. DON or designee will audit five care plans monthly for 6 months or until corrected and report findings to QA committee quarterly. cont.	

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	43A038		09/10/2014

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F 280	Continued From page 25 resident with eating/drinking at all meals." -Review of the Assist to eat program care plan revealed: --"Resident will be sit at the assist to eat table with staff extensively helping her consume 25-100% of 2-3 meals daily" --"Resident will be cued to open mouth, or wake up when falling asleep or eyes are closed as food is consumed." Observation on 9/8/14 at 5:00 p.m. through 5:30 p.m. and on 9/9/14 at 11:25 a.m. through 12:00 noon revealed resident 4 had sat in her wheelchair. Staff had performed all the eating tasks. She had not been handed any devices or cued to eat. c. Review of resident 7's medical record revealed: *He had been admitted on 1/28/14. *His diagnoses had been: -Confusion. -Diabetes Mellitis. -Dementia. -COPD (chronic obstructive pulmonary disease-breathing difficulties). -BPH (benign prostatic hypertrophy-enlarged prostate). -Macular degeneration. -Diabetic retinopathy (disease of the eye caused by diabetes). -Hypertension -Hyperlipidemia -Peripheral artery disease (decreased blood flow to lower legs). -CVA (stroke). -Ataxia (difficulty walking). -Anxiety. -Organic heart disease (decline in heart function). -Depression.	F 280	c. Resident 7's care plan has been reviewed and revised to read thicken liquids to nectar consistency per physician's order. DON or designee will audit five care plans monthly for 6 months or until corrected and report findings to QA committee quarterly. CNA A and all care staff have been instructed and educated how to thicken liquids to appropriate consistency as ordered by the physician by following the recommended instructions on the product. DON or designee will monitor thicken liquids given to residents for appropriate consistency once weekly for one month than monthly for 5 months or until corrected and report findings to care staff and QA committee quarterly. [redacted]	XG0004MF

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F 280	Continued From page 26 *His revised 2/4/14 care plan revealed: -Focus area of "Risk for dehydration/deficient fluid volume." -No notation of thicken liquids. Observation on 9/8/14 from 5:00 p.m. through 5:30 p.m. and on 9/9/14 at 11:25 a.m. through 12:00 noon revealed resident 4 had liquids that had been thickened. Interview on 9/8/14 at 5:15 p.m. with certified nursing assistant (CNA) A revealed his liquids were to have been thickened. She was unable to tell me the consistency of the thickening needed. Review of the 5/1/14 Assist-to-eat care plan revealed an intervention of "Staff will assist resident with meals, liquids thickened to prevent choking, aspiration." There had been no mention as to the consistency needed for the thickened liquids. *Review of the current signed and undated physician's orders revealed resident 4's diet order to have been "Diabetic diet with thickened liquids." The order did not mention the consistency. d. Interview on 9/10/14 at 10:20 a.m. with the chief nursing officer (CNO) confirmed she would have expected the care plans to reflect the current resident status. Review of the provider's revised May 2013 Care Plan policy revealed the purpose as "A guide to patient/resident-centered care, to provide a means of communication to all those caring for the patient/resident, and to stimulate a feeling of unity among the nursing personnel."	F 280		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281		

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F 281 SS=E	Continued From page 27 PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on interview, record review, and policy review, the provider failed to ensure professional standards had been followed: *For the clarifying of physician's orders for one of nine sampled residents (2). *For the noting of physicians' orders by the nurse for seven of nine sampled residents (1, 2, 3, 4, 7, 8, and 9). *For thorough wound documentation for one of three sampled residents (4) with a wound. Findings include: 1. Review of resident 2's September 2014 medication administration record (MAR) revealed: *Coumadin 6 milligrams (mg) was given on Sunday and Wednesday. *Coumadin 3 mg was given the other days of the week. Review of resident 2's physician's orders revealed: *A telephone order on 6/26/14 for the Coumadin to be given 6 mg on Sunday and Wednesday and 3 mg on the other days of the week. *The physician had not dated when he had signed those orders. *On 7/8/14 the physician had signed a recapitulation (summary) of the resident's orders that had been reviewed by a nurse on 6/26/14. *Those recapitulated and reviewed orders had	F 281	F281 Directed In-service held with nursing staff on Oct. 2nd. Policies reviewed regarding physician orders and documentation of wounds. Education provided for receipt, clarification, and actual note and implementation of orders. Wound care documentation should be specific and complete. [redacted] 1. Resident 2's physician orders were reviewed and put into proper sequence and verified that orders were current and noted by the DON. All other resident orders will be reviewed at month end (Sept 29-30th), updated and given to the physician to review and sign the date of completion. DON will note and place in charts. Charge nurse will check and note off accordingly. DON or designee will monitor five random charts monthly for proper notation of physician orders for 6 months or until corrected. Findings will be reported by the DON to the QA committee quarterly. cont.	10/30/14 KG0004MF

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F 281	Continued From page 28 included Coumadin 6 mg on Sunday and 3 mg on the other days of the week. *On 7/28/14 a telephone order had been received from the physician to continue the same Coumadin dose. *The most current Coumadin orders had been the recapitulated orders signed by the physician on 7/8/14 as they were the last signed and dated orders from the physician for Coumadin. *Those orders had not been what was documented as having been given to the resident on the MAR. Interview on 9/10/14 at 12:45 p.m. with the chief nursing officer confirmed: *The physician had not dated the 6/26/14 telephone orders when he had signed them *She had believed the 6/28/14 telephone orders had been placed "on top" of the 7/8/14 recapitulated orders in the chart. *She had believed that had made them the most current orders. *She had not believed the dates a physician had signed an order made it the most current order. *The system used was not effective in ensuring orders were noted, and the recapitulated orders were updated from when they had been printed until the physician had signed those orders. 2. Review of residents 2, 3, and 9's recapitulated physicians' orders revealed: *Resident 2's recapitulated orders had been signed by the physician on 7/8/14. -They had been reviewed by a nurse on 6/26/14. *Review of resident 3's recapitulated orders had been signed by the physician on 8/11/14. -They had been reviewed by a nurse on 7/29/14. *Review of resident 9's recapitulated physician orders had been signed by the physician on	F 281	2. Resident 2, 3, and 9's physician orders were reviewed and put into proper sequence and verified orders were current and noted by the DON. All other resident orders will be reviewed con't.	

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F 281	Continued From page 29 6/26/14. -They had been reviewed by a nurse on the same day. *None of the above recapitulated orders had been noted by a nurse after the physician had signed the orders. Interview on 9/10/14 at 12:45 p.m. with the chief nursing officer confirmed the expectation had been all orders were to have been noted off by a nurse after the physician had signed them. Review of the provider's January 2008 Physician's Orders policy revealed the nurse transcribing the orders was to have: *Bracketed, dated, added the time, and signed her name to the orders on the left side of the orders. *That was considered the noting off of orders. *Only a licensed nurse could note off orders in the accepted above manner. Surveyor: 32572 3. Review of residents 1, 4, 7, and 8's medical records revealed physicians' orders had been reviewed prior to the physician visit. The physician had signed the orders, and then the orders had not been noted by licensed nursing staff. 4. Review of resident 4's medical record revealed the provider failed to accurately complete wound documentation in one or more of the following areas: *Location. *Wound type. *Exudate (drainage). *Wound bed (bottom of the wound). *Surrounding skin color. *Wound edges/surrounding tissue.	F 281	at month end (Sept 29-30th), updated and given to the physician to review and sign the date of completion. DON will note and place in charts. Charge nurse will check and note off accordingly. DON or designee will monitor five random charts monthly for proper notation of physician orders for 6 months or until corrected. Findings will be reported by the DON to the QA committee quarterly. 3. Resident 1, 4, 7, and 8's physician orders have been reviewed and put into proper sequence and verified that orders were current. Orders checked and noted off by DON accordingly. DON or designee will monitor five random charts monthly for proper notation of physician orders for 6 months or until corrected. Findings will be reported by the DON to the QA committee quarterly. 4. Directed In-service conducted on Oct. 2nd included: Resident 4's prior wound care sheets were reviewed with cont.	

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F 281	Continued From page 30 The weekly documentation records for the following months in 2014 revealed missing documentation for: *Five of five completed for August. *Three of three completed for July. *Four of four completed for June. Interview on 9/10/14 at 10:20 a.m. with the chief nursing officer (CNO) confirmed she would have expected the forms to have been fully completed. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, MO., 2005, p.282, revealed "Assessment data must be descriptive, concise, and complete."	F 281	nursing staff and educated regarding completion of all applicable areas. Each area must be addressed and specific measurements documented. DON or designee will monitor all residents wound care sheets weekly for completion for one month than monthly for 5 months or until corrected. Findings will be reported by DON to nursing staff at monthly and QA committee quarterly.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, record review, and interview, the provider failed to ensure grab/positioning bars had been used in a safe manner to prevent potential injury for nine of nine sampled residents (1, 2, 3, 4, 5, 6, 7, 8, and 9). Findings include:	F 323		

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F 323	Continued From page 31 1. Observation on 9/8/14 from 2:30 p.m. through 9/10/14 until 1:00 p.m. revealed all of resident 1, 2, 3, 4, 5, 5, 6, 7, 8, and 9's beds had grab/positioning bars attached to them. Some of the beds had a rail on one side, and others had one attached to each side of the bed. 2. a. Observation during the survey revealed resident 2 had a grab/positioning bar on the upper right side of her bed. Review of resident 2's complete medical record revealed she: *Had been admitted on 9/13/13. *Had a diagnosis of dementia. *Had a history of falls. *Had no assessment for the use of the grab/positioning bar. Review of resident 2's care plan revealed no mention of the use of grab/positioning bars. b. Observation during the survey revealed resident 3 had a grab/positioning bar on the upper left side of her bed. Review of resident 3's complete medical record revealed she: *Had been admitted on 11/2/12. *Had a diagnosis of dementia. *Had no assessment for the use of the grab/positioning bar. Review of resident 3's care plan revealed no mention of the use of the grab/positioning bar. c. Resident 9 had two of the grab/positioning bars on the head of her bed.	F 323	Resident 1,2,3,4,5,6,7,8, and 9 and all residents were assessed to determine if a grab bar(s) is safe for use. DON or designee will assess all residents upon admission and with significant changes of health status as defined by the MDS to determine if grab bar(s) are safe for use. 2. a. Resident 2 and all resident care plans have been revised to include or exclude grab bar(s) use after an assessment was completed. Grab bar(s) was removed. b. Resident 3 and all resident care plans have been revised to include or exclude grab bar(s) use after an assessment was completed. Grab bar(s) was left in place. c. Resident 9 and all residents care plans have been revised to include or exclude grab bar(s) use after an assessment was completed. Grab bar(s) was left in place.	

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F 323	Continued From page 32 Review of resident 9's complete medical record revealed she: *Had been admitted on 8/18/07. *Had a diagnosis of dementia. *Had no assessment for the use of the grab/positioning bar. Review of resident 9's care plan revealed no mention of the use the grab/positioning bar. Surveyor: 29162 d. Observations from 2:30 p.m. on 9/8/14 through 1:00 p.m. on 9/10/14 of resident 5's room revealed she had one grab/positioning bar on the upper part of her bed. Review of resident 5's complete medical record revealed no assessment for the use of a grab/positioning bar. Review of resident 5's current care plan revealed no mention of a grab/positioning bar. e. Observations from 2:30 p.m. on 9/8/14 through 1:00 p.m. on 9/10/14 of resident 6's room revealed she had two grab/positioning bars on the upper part her bed. Review of resident 6's complete medical record revealed no assessment for the use of a grab/positioning bar. Review of resident 6's current care plan revealed no mention of a grab/positioning bar. Surveyor: 32572 f. Observations from 2:30 p.m. on 9/8/14 through 1:00 p.m. on 9/10/14 of resident 1's room	F 323	d. Resident 5 and all resident care plans have been revised to include or exclude grab bar(s) use after an assessment was completed. Grab bar(s) was removed. e. Resident 6 and all resident care plans have revised to include or exclude grab bar(s) use after an assessment was completed. Grab bar(s) was removed. f. Resident 1 and all resident care plans have been revised to include or exclude grab bar(s) use after an assessment was completed. Grab bar(s) was left in place.	

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F 323	Continued From page 33 revealed she had one grab/positioning bar on the upper part of her bed. Review of resident 1's complete medical record revealed no assessment for the use of a grab/positioning bar. Review of resident 1's current care plan revealed no mention of a grab/positioning bar. g. Observations from 2:30 p.m. on 9/8/14 through 1:00 p.m. on 9/10/14 of resident 4's room revealed she had one grab/positioning bar on the upper part of her bed. Review of resident 4's complete medical record revealed no assessment for the use of a grab/positioning bar. Review of resident 4's current care plan revealed no mention of a grab/positioning bar. h. Observations from 2:30 p.m. on 9/8/14 through 1:00 p.m. on 9/10/14 of resident 7's room revealed he had two grab/positioning bars on the upper part of his bed. Review of resident 7's complete medical record revealed no assessment for the use of a grab/positioning bar. Review of resident 7's current care plan revealed no mention of a grab/positioning bar. i. Observations from 2:30 p.m. on 9/8/14 through 1:00 p.m. on 9/10/14 of resident 8's room revealed she had two grab/positioning bars on the upper part of her bed. Review of resident 8's complete medical record	F 323	g. Resident 4 and all resident care plans have been revised to include or exclude grab bar(s) use after assessment completed. Grab bar(s) removed. h. Resident 7 and all resident care plans have been revised to include or exclude grab bar(s) use after assessment completed. Grab bar(s) removed. i. Resident 8 and all resident care plans have been revised to include or exclude grab bar(s) use after an assessment completed. Grab bar(s) kept in place. Physician's educated about survey results and F323 deficiency regarding use of grab bar(s) and resident safety and assessment. Grab bar(s) use will be a PRN standing order upon admission dependent upon assessment results. DON or designee will audit 5 random charts and care plans monthly for 5 months or until corrected for the following:	

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F 323	Continued From page 34 revealed no assessment for the use of a grab/positioning bar. Review of resident 8's current care plan revealed no mention of a grab/positioning bar. None of the above nine residents had physician orders for the use of the grab/positioning bars. Surveyor: 29162 Interview on 9/10/14 at 10:30 a.m. with the chief nursing officer revealed there had been no safety assessments completed for any of the grab/postioning bars on the above resident's beds. She stated they did not anticipate a safety issue with their use. She agreed residents that were not able to use the grab/postioning bars should not have had them on their beds. She agreed the grab/postioning bars had not been included on the residents' care plans.	F 323	1. Physician ordered grab bar(s) 2. Assessment for grab bar(s) 3. Revised care plans to include/exclude grab bar(s) *10/30/14 DON will report findings to QA [redacted] committee quarterly. [redacted] KG/10/14 mF	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, interview, and policy review, the provider failed to prepare, serve, and	F 371		

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F 371	Continued From page 35 store food in a safe and sanitary manner by one of two cooks (F) and three of three observed dietary aides (C, D, and E) during two of two observed meals. Findings include: 1. Observation on 9/8/14 at 2:45 p.m. revealed individual serving dishes of pears had been placed in the refrigerator. They had not been covered. Observation on 9/8/14 at 5:25 p.m. revealed the uncovered pears were removed from the refrigerator and placed next to the steam table. The dishes had then been covered with parchment paper until they were served to the residents. Observation on 9/9/14 at 11:30 a.m. revealed individual serving dishes of watermelon had been placed in the refrigerator. They had not been covered. Observation on 9/8/14 at 11:45 a.m. revealed the uncovered watermelon was removed from the refrigerator and placed next to the steam table. They had then been covered with parchment paper until they were served to the residents. A list with a request for a food storage policy on 9/10/14 was given to the chief nursing officer. No policy had been offered to the survey team by exit on 9/10/14 at 2:35 p.m. 2. Observation on 9/8/14 at 4:25 p.m. during the supper meal revealed cook F: *While wearing the same gloves: -Handled slices of toast as he cut them and placed them into the warner on the steam table. -Turned the warmer light switch on above the	F 371	F371 1. Aides will cover fruit/desserts with plastic wrap, foil or lid when dished and put in refrigerator and will remain covered until serving. AM cooks will check the breakfast and lunch fruit/desserts for proper storage 3 times per week for one month than one time per week for 5 months or until corrected. Findings will be reported to the QA committee by Dietary manager or designee. [redacted] 2. Cook F and all dietary staff [redacted] instructed on when to discard contaminated gloves and how to properly handle ready-to-eat foods. Cook F and all dietary staff [redacted]	10/30/14

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	43A038		09/10/2014

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F 371	Continued From page 36 toast. -Put oven mitts on over his gloves and removed food from the oven. -Used a thermometer to check the temperature of that food. -Removed the oven mitts and his gloves. *Without washing his hands pureed food and placed it on the steam table to stay warm. *Went to the dishwasher area and washed the blender used to puree the food. *Washed his hands when he had finished that task. *Turned the faucet off with a clean paper towel. *Dried his clean hands on that contaminated paper towel. *Every time he had washed his hands he had turned the faucet off with a paper towel that he then used to dry his clean hands. *Had adjusted his glasses and his hat frequently with his gloved hands. *Had opened the refrigerator with his gloved hands. *Had touched the ready-to-eat toast with those same gloves as he placed it onto all of the residents' plates. *Had handled the clean plates the residents' meals had been served on. 3. Observation on 9/8/14 from 4:25 p.m. through 6:00 p.m. during the supper meal and on 9/9/14 from 11:30 a.m. through 12:00 noon during the noon meal service revealed the following dietary staff had failed to cover their hair in a hygienic manner: *Dietary aide E had her hair in a long pony tail. -She had a head band on. -She swung her pony tail back and forth frequently as she had gone about her duties serving food to the residents.	F 371	washing technique. Dietary manager or designee will monitor glove use of dietary staff three times per week for one month than once weekly for 5 months or until corrected. Findings will be reported by dietary manager to QA committee quarterly. Dietary manager or designee will monitor all dietary staff hand washing technique three times weekly for one month than weekly for 5 months or until corrected. Findings will be reported by Dietary manager to QA committee quarterly. 3. Dietary aide E, Cook F, Dietary aide C, and Dietary aide D and all dietary staff instructed they must wear hair nets while working at all times with hair tucked into their hair nets. Dietary manager or designee will monitor that all staff is properly wearing their hair nets three times weekly for one month than weekly for 5	[redacted]

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F 371	Continued From page 37 *Cook F wore a baseball cap. -That cap had been soiled. -He had touched it frequently as he had prepared and served food to the residents. *Dietary aides C and D had worn baseball caps while they had worked in the kitchen. -Their hair had extended outside of their caps. Review of the provider's 6/17/10 reviewed Dietary policy found in the infection control book by the surveyor revealed: *Thorough and frequent handwashing was the most important procedure for preventing infection. *Hands were to have been washed between tasks. *It had not addressed the use of gloves. *It had not addressed the storage of dished foods. *It had not addressed a procedure for hair hygiene while preparing and serving food. 4. Interview on 9/10/14 at 9:55 a.m. with the dietary manager confirmed: *She had noticed the fruit had not been covered in the refrigerator when it had been placed in the individual serving dishes. *She agreed it had been at risk for contamination when it had not been covered. *She had agreed hands needed to be washed when gloves had been changed. *Gloves should have been clean or changed between tasks and before touching ready-to-eat foods. *Hands should not be dried with the same towel used to turn the faucet off with. *That would have caused the hands to be contaminated from the soiled faucet handle.	F 371	months or until corrected. Findings will be reported by Dietary manager to QA committee quarterly. 4. Directed In-service held Oct. 2nd with all staff instructing proper storage of individual serving dishes with plastic wrap, foil or a lid. Reviewed when to discard contaminated or soiled gloves and how to properly handle ready-to-serve foods. Proper hand washing technique reviewed. Hair nets are required to be worn by all dietary staff when working at all times.	[redacted]

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F 371	Continued From page 38 *She had not been sure how hair should have been covered while preparing foods. *She agreed a hair net would better cover all of the hair.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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F 431	Continued From page 39 This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation and interview, the provider failed to ensure medications were properly secured during two of two observed medication passes by two of two unlicensed assistive personnel (UAP) (G and H). Findings include: 1. Observation on 9/8/14 from 5:10 p.m. through 5:45 p.m. of UAP G revealed she passed medication to ten different random residents in the dining room. While she passed those medications she had left the medication cart unattended. At times her back had been turned on the medication cart, and she had been across the dining room. There had been residents and staff in the dining room that could have had access to the unlocked medication cart. 2. Observation on 9/9/14 from 7:50 a.m. through 8:15 a.m. of UAP H revealed she passed medication to six different random residents in the dining room. While she passed those medications she had left the medication cart unattended. At times her back had been turned on the medication cart, and she had been across the dining room. There had been residents and staff in the dining room that could have had access to the unlocked medication cart. Interview on 9/10/14 at 8:15 a.m. with the chief nursing officer confirmed the medication cart should have been locked by UAPs G and H when they had not been in attendance of it.	F 431	F431 1. UAP G and all UAP's instructed to [redacted] keep the medication cart within sight at all times and to lock the medication cart when left [redacted] unattended. 2. UAP H and all UAP's instructed to [redacted] keep medication cart within sight at all times and lock the medication cart if left unattended. DON or designee will monitor one medication pass three times weekly for one month then weekly for 5 months or until corrected. Findings will [redacted] be reported by DON to QA committee quarterly.	

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F 431	Continued From page 40 Review of the provider's last revised August 2013 Administration of Medications policy revealed: *Only licensed personnel were to have had access to the medication cart. *The medication cart was to have been locked when in a common area of the nursing home.	F 431		
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 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F441 Directed In-service conducted Oct. 2nd and CNO reviewed survey deficiencies. Reeducated staff how to perform hand hygiene and don gloves. When to discard soiled gloves and don clean gloves when providing personal care with residents. [redacted] KG/SOD/HMF	10/30/14

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F 441	Continued From page 41 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, and policy review, the provider failed to ensure the facility had been maintained in a sanitary manner and resident use items were used and sanitized in a proper manner for the following: *Providing appropriate hand washing and glove use during one of three resident's (4) personal care by one of three certified nursing assistant's (CNA) B. *Ensuring appropriate hand hygiene by one of one activitiy director and one of six CNAs (A) during one of two dining room observations. *Two of six rolling dining room stools had cracked covers exposing the foam padding causing an uncleanable surface (photo 1). *Appropriate use, storage, and labeling of single resident use personal care supplies for 30 of 30 residents, one of one bathroom in the bathing area (photo 2), and by two of two CNAs (A and J) while providing care to resident 6. *Sanitizing of the blood glucose meter case during one of one residents' (7) observed blood glucose test done by registered nurse (RN) I. Findings include: 1. Observation on 9/9/14 at 9:43 a.m. revealed personal care provided to resident 4 by CNA B revealed she had:	F 441	1. Instructed CNA B and all care staff when giving care to resident 4 and all residents to perform proper hand hygiene prior to donning gloves and discard soiled gloves when contaminated. A new pair of gloves should have been donned after giving perineal care or touching contaminated surfaces in resident rooms before touching resident again. Don or designee will monitor one CNA staff from various shifts for proper hand hygiene and glove use three times weekly for one month than once weekly for 5 months or until corrected. Findings will be reported by DON to QA committee quarterly.	

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F 441	Continued From page 42 *Put on gloves without washing her hands. *Provided personal care. *The resident had a bowel movement after cleansing her. *She had obtained more personal care supplies from resident 4's dresser. *Then provided personal care to the resident again. *Then applied a clean incontinent product and pulled her clothing. *Then used the mechanical lift to place the resident into her wheelchair. *Then removed her gloves and adjusted the resident's slacks up. *Touched multiple resident surfaces. She had not changed the gloves after they had become dirty nor had she completed hand washing. 2. Observation on 9/9/14 from 5:00 p.m. through 5:30 p.m. revealed CNA A had been assisting unidentified residents their evening meals. During that observation she had gone from resident to resident at different tables assisting them with their meals. The residents had touched their silverware along with the CNA. Hand hygiene had not been performed during any of that time. Observation on 9/10/14 from 11:25 a.m. thorough 12:00 noon revealed the activity director had been assisting unidentified residents with their noon meals. During that observation she had gone from resident to resident at different tables assisting them with their noon meals. The residents had touched their silverware along with the activity director. Hand hygiene had not been performed during any of that time. 3. Review of the provider's revised January 2006 Perineal Care policy revealed it did not direct staff	F 441	2. Instructed CNA A, activity director and all care staff about proper hand hygiene prior to assisting residents with meals. They should conduct proper hand hygiene whenever they touch contaminated surfaces, other residents or themselves prior to assisting residents to eat. DON or designee will monitor staff assisting residents in dining room to assure proper hand hygiene occurs at the appropriate time three times weekly for one month than weekly for 5 months or until corrected. Findings will be reported by the DON to care staff at monthly meetings and QA committee quarterly.	[redacted]

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F 441	Continued From page 43 when to complete hand washing. Review of the provider's revised May 2011 Hand washing policy revealed "The single most important measure in the prevention and control of infection is hand washing. Before touching the resident or any equipment used in caring for the resident, your hands must be washed or they are considered dirty or contaminated." The policy listed some specific times hand washing "must be done" such as: *"Before donning [putting on] gloves and after removing gloves." *"Before having contact with the resident's face and mouth." *"After ...assisting the resident in the bathroom." Review of the provider's reviewed 1/18/08 Feeding a Patient policy revealed it did not state when hand washing was to have occurred. Interview on 9/10/14 at 12:35 p.m. with the chief nursing officer (CNO) confirmed she would have expected hand washing and glove use to have occurred at the appropriate times. 3. Observation on 9/9/14 at 11:25 a.m. revealed two rolling dining room stools had cracks or tears in the covering. Those areas caused the foam to be exposed creating an uncleanable surface. Those stools had been used by CNAs in assisting residents with their meals. Interview on 9/10/14 at 9:30 a.m. with the CNO confirmed the cracks or tears had created uncleanable surfaces. Review of the provider's undated revised Infection Control program revealed the goal had been to minimize the spread of infections.	F 441	3. Perineal policy was reviewed and updated to include appropriate times to perform hand hygiene and don gloves. The policy for feeding a resident was reviewed and updated to include when to perform proper hand hygiene. DON or designee will review policies annually. [redacted] 3. The two identified rolling stools with exposed foam have been recovered. DON or designee will monitor all rolling stools for uncleanable surfaces monthly for 6 months. Findings to be reported by DON to QA committee quarterly. [redacted]	

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F 441	Continued From page 44 Surveyor: 29162 4. Observation and interview on 9/8/14 from 4:40 p.m. through 4:55 p.m. of CNA J while she provided care to resident 6 revealed she used the bottle of foam cleanser that had been sitting on the sink. The cleanser was used while personal care was provided to the resident. CNA J laid the bottle of foam cleanser directly onto the resident's bed sheet and bedspread. When she was done using the cleanser CNA J returned the bottle to the top of the sink. She did not clean or sanitize the bottle before she put it back on the sink. She stated she used the same bottle of cleanser for both residents in the room. Observation on 9/9/14 at 11:30 a.m. of CNA A while she provided care for resident 6 revealed she used the bottle of foam cleanser from the sink in the resident's room. She laid the bottle of cleanser directly on the resident's bed sheets. When she had finished using the cleanser she returned it to the sink. She did not clean or sanitize the bottle before she placed it back on the sink. She stated she used the same bottle of cleanser for both residents in the room. Interview on 9/9/14 at 8:30 a.m. with RN I confirmed the same bottle of foam cleanser was used for both the residents in a room. Interview on 9/10/14 at 1:00 p.m. with the CNO revealed her expectation of best practice was for each resident in a room to have had their own bottles of foam cleanser and other personal care items. 5. Observation on 9/9/14 at 10:50 a.m. of RN I while she completed a blood glucose test for	F 441	4. Instructed CNA J, CNA A and RN I and all care staff that resident 6 and all residents have their own personal cleansers. When providing perineal care staff is to use each resident's personal cleanser and not interchange them. All resident foam cleansers have been labeled with names and bed number. DON or designee will monitor one CNA on various shifts when giving personal care to residents to assure that staff is using their personal products three times weekly for one month than weekly for 5 months or until corrected. DON will report findings at monthly staff meetings and QA committee quarterly. 5. RN I and all nursing staff instructed to clean meter after each use and meter case after use if brought into a resident room after blood glucose testing for resident 7 and all applicable	KG/SDD4/MF [redacted] [redacted] KG/SDD4/MF

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F 441	Continued From page 45 resident 7 revealed she laid the blood glucose meter case directly on top of the resident's bedside table. When she was done with the test she sanitized the blood glucose meter but not the case. She returned the case to the treatment cart without sanitizing it.	F 441	residents. DON or designee will monitor nursing staff for sanitizing blood glucose meter after each use and meter case if brought into resident room to assure proper cleansing before next use three times weekly for one month than once monthly for 5 months or until corrected. Finding will be reported by DON to QA committee quarterly.	KG/SDDH/MF X [redacted] X [redacted] KG/SDDH/MF

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ORIGINAL

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILIDING 01 B. WING	(X3) DATE SURVEY COMPLETED
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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 9/09/14. Philip Nursing Home 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 K062 and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 10/3/14 telephone to facility administrator. KG/SDDOH/MF	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the generator as required. A remote stop for the generator was not installed. Findings include: 1. Observation at 10:00 a.m. on 9/09/14 revealed the generator providing power for emergency	K 144	K144 Remote manual stop station connected to generator will be installed by October 30, 2014 by Maintenance personnel. Maintenance Director and Administrator will review and ensure process is completed. Administrator will monitor on a monthly basis as per preventive maintenance program. Audit sheets will be monitored by the Administrator and submitted quarterly by the Maintenance Director at the quarterly QI Committee meeting. * [redacted] KG/SDDOH/MF	10/30/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: CEO/ADMINISTRATOR (X6) DATE: 10/3/14

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILIDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED
	43A038		09/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHILIP NURSING HOME	503 WEST PINE POST OFFICE BOX 790 PHILIP, SD 57567

(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 144	Continued From page 1 lighting was found to be lacking a remote manual stop station as required. That should be mounted outside of the all-weather enclosure when the prime mover is located outside of the building. Interview with the director of plant operations confirmed that condition. This deficiency affected a single location required to be equipped with remote emergency stops.	K 144	K046 Emergency light at the emergency power switch battery has been repaired as of 9/9/14. Maintenance Director will monitor and review this light on a monthly basis as per preventive maintenance plan. Audit sheets will be monitored by the Administrator and submitted quarterly by the Maintenance Director at the quarterly QI Committee meeting. KKDDDHIME [redacted] K062 Quarterly automatic sprinkler inspections will be completed on a timely basis. Maintenance Director and Administrator will monitor and review as per preventive maintenance plan. Audit sheets will be monitored by the Administrator and submitted quarterly by the Maintenance Director at the quarterly QI Committee meeting. KKDDDHIME [redacted]	10/30/14 10/30/14

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

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 43A038	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILIDING 01 B. WING	DATE SURVEY COMPLETE 9/9/2014
NAME OF PROVIDER OR SUPPLIER PHILIP NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 503 WEST PINE POST OFFICE BOX 790 PHILIP, SD		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 046	NFPA 101 LIFE SAFETY CODE STANDARD
X [redacted]	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.
[redacted] KG SDDH/MF	This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to provide emergency lighting of at least one hour duration in the electrical room. The emergency light at the transfer switch did not work Findings include: 1. Observation and testing at 10:00 a.m. on 9/09/14 revealed the emergency light at the emergency power transfer switch did not work. Interview with the director of plant operations at the time of the observation revealed he did have testing of that emergency light on the preventive maintenance schedule The battery for the unit was replaced during the survey. This deficiency affected a single location required to be equipped with emergency battery pack lighting
K 062	NFPA 101 LIFE SAFETY CODE STANDARD
X [redacted]	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
[redacted] KG SDDH/MF	This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to ensure the automatic sprinkler system had required quarterly flow testing performed as required during the previous twelve months beginning July2013. There was a five month break between two of the quarterly inspections(February to July 2014). Findings include: 1. Review of the provider's automatic sprinkler system inspection reports on 9/09/14 revealed quarterly flow testing documentation for the twelve month period beginning July2013 was performed 8/21/13, 11/14/13, 2/25/14, and 7/24/14. There was a five month period of time between the February and July reports(a two month lapse). Interview with the plant operations director at the time of the record review revealed he was hampered by the vendor's lack of response to his request to perform quarterly flow tests as required This deficiency could potentially affect all thirty residents of the facility.

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The above isolated deficiencies pose no actual harm to the residents

031099

ORIGINAL

PRINTED: 09/19/2014
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	10661		09/10/2014

NAME OF PROVIDER OR SUPPLIER: PHILIP NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 503 W PINE POST OFFICE BOX 790, PHILIP, SD 57567

(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 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 9/08/14 through 9/10/14. Philip Nursing Home was found in not compliance with the following regulation: S166.	S 000	Addendums noted with an asterisk per 10/15/14 telephone to facility administrator. KG/SDDOH/MF	
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed; (7) Portable space heaters and portable halogen	S 166	S166 Shatterproof heat lamps have been installed in the two tub rooms. Maintenance Director and Administrator will monitor and review as per the preventive maintenance plan. Audit sheets will be monitored by the Administrator and submitted quarterly by * [redacted] the Maintenance Director at the quarterly QI Committee meeting. KG/SDDOH/MF	10/30/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kent Olson

TITLE: CEO/Administrator

(X6) DATE: 10/6/14

STATE FORM 6899 E8JY11 If continuation sheet 1 of 2

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	10661		09/10/2014

NAME OF PROVIDER OR SUPPLIER

PHILIP NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

503 W PINE POST OFFICE BOX 790
PHILIP, SD 57567

(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 166	Continued From page 1 lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to equip overhead light fixtures in two of two tub rooms with shatterproof lamps. Findings include: 1. Observation beginning at 10:00 a.m. on 9/09/14 in the two tub rooms revealed an overhead heat lamp in each of the tub rooms without a cover. Further observation revealed the lamps were not shatterproof. Interview with the director of plant operations at the time of the observation revealed he was unaware the heat lamps were not shatterproof. He ordered new heat lamps for the tub rooms during the survey.	S 166		