

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

PRINTED: 07/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/19/2014
NAME OF PROVIDER OR SUPPLIER PLATTE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 609 EAST 7TH POST OFFICE BOX 200 PLATTE, SD 57369	
(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 170 SS=E	<p>483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL</p> <p>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, it was determined that the facility failed to ensure that mail was delivered to the residents on Saturday since there was Saturday mail delivery in the community. The findings included:</p> <ol style="list-style-type: none"> 1. On 6/18/14 during the group interview, seven residents were in attendance. The residents brought up the concern about not getting their mail delivered on Saturdays. The residents reported that the mail comes to the post office but there was not a staff member to get the mail to the nursing home. They reported they had been told that the nursing home and hospital mail went to the same post office box and the hospital does not pick up the mail on Saturdays. 2. Review of the Resident Council Minutes for 5/22/14 noted the residents had brought up the issue of not getting Saturday mail. 3. In an interview with the Administrator on 6/19/14 at 8:45 AM, he confirmed the residents' concern with not getting Saturday mail had been brought up in the past. He stated that the residents are given a choice of having their mail delivered to the nursing home (which would have Saturday delivery) or the hospital post office box 	F 170	<p>It is recognized that residents have the right to send/ receive unopened mail and that mail delivery was not ensured to residents on Saturday. The residents' address has been changed to 601 E 7th Street, Platte, SD 57369 and mail will be delivered Monday through Saturday to a post office box located at this above address. Social service staff will pick-up/distribute the mail Monday through Friday and Saturday mail will be picked-up/ delivered by CNA staff and/or RA. On July 21, 2014 family members/responsible parties were sent a letter explaining address change with enclosed address change cards to be filled out and returned to post office to ensure this change of address. Residents will be informed of this change at the next Resident Council Meeting scheduled for 7-23-14 and any new admits will be given this new address upon admittance to the Care Center. Start date will be August 1, 2014 to allow family members/responsible parties ample time to get address change cards completed. Starting on September 1, 2014 the Social Services Designee will be assessing address changes and following up with family members/ responsible parties if resident mail is still arriving at the previous address. Social Services Designee will report compliance on the Care Center dashboard monthly and report to the Platte Health Center Quality Team monthly beginning September 2014.</p>	08/01/14

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

TITLE

(X6) DATE

CEO

7/10/14

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 (which would not have Saturday delivery, but would allow the residents to receive their local weekly paper a day earlier than if the mail came to the nursing home). He reported that the nursing home and hospital mail goes into the same post office box, the hospital did not pick up Saturday mail, and it would be a privacy issue if the nursing home staff picked up hospital and nursing home mail.	F 170		
F 246 SS=E	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident, family, and staff interview, it was determined that the facility failed to ensure that residents' call lights were answered in a timely manner in order to meet the residents' needs. The findings included:</p> <ol style="list-style-type: none"> 1. On 6/18/14 at 4:50 PM, in a confidential family interview, the family member revealed that the call light wait time is sometimes 15 minutes and that on the evening shift there was only one staff member (Certified Nurse Aide) for about one month. When staff doesn't come promptly, the family member says the resident starts yelling. 2. On 6/19/14 at 3:50 PM, in a confidential 	F 246	<p>It is accepted that residents should expect that staff answer call lights and address resident's needs in a timely manner. It is acknowledged that several residents have voiced concerns that call lights are not answered in a timely manner, residents are left on the toilet for too long and that there are times when staff did not return as promised after answering a call light. It was also acknowledged that one family member reports that there was only one CNA in the evening shift for a month. It is the goal of the Platte Care Center to answer all call lights in less than ten minutes. In addition if a CNA answers a call light and is unable to address the residents need immediately they will give the resident a time frame of when they will return to address the need. If unable to address the need in that time frame they will see to it they return and speak to the resident, or have another staff member address that resident's need. Nursing and CNA staffs were educated on this subject at the meetings on July 15 & 16, 2014. DON will run monthly audits beginning August 2014 and assess for trends of staff not answering call lights in a timely manner and what time of day these prolonged call light occurs. These results will be brought to CNA and Nurse Meetings starting in August 2014. DON will follow up with random interviews of residents to assess if resident feels call light answering has met their expectations beginning August 2014. DON will include residents who are identified as having prolonged call lights in interviews. DON will report compliance on the care center dashboard monthly beginning August, 2014 and report to the Platte Health Center Quality Team monthly beginning in October 2014.</p>	07/18/14

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F 246	<p>Continued From page 2</p> <p>resident interview, the resident verified that she does use the call light to call for assistance. She indicated that the call light wait times are sometimes 10 - 15 minutes.</p> <p>3. On 6/18/14 during the group interview, seven residents were in attendance. There were six residents who reported concerns with how long it took for staff to answer lights. The concerns expressed included call light wait times which were from 10 to 20 minutes. The residents also expressed concerns with the lack of assistance in the dining room on weekends. The residents' statements included:</p> <p>a) "It is too long if you are sitting on a toilet."</p> <p>b) "I have had staff come in and say 'I will be right back' and then they don't return. I think that seems to be the norm."</p> <p>c) "It is totally different here on weekends and seems short handed and I know it takes longer to get lights answered. The (residents) also don't get as much help in the dining room."</p> <p>d) "I know sometimes it takes a little while to get the lift and extra staff to help but when they don't come back it is frustrating."</p> <p>4. On 6/18/14 during a confidential family interview, the family member indicated that call lights were a problem because the call lights get turned off and staff don't assist the residents timely. Additionally, their family member, who is dependent on staff for assistance, had been left unattended in the bathroom.</p> <p>5. On 6/19/14 at 1:45 PM, in an interview with the</p>	F 246	<p>In review of the schedules for the past year there has never has been less than 4 CNA's on the floor during the evening shift and the average staffing pattern is between 5-6 CNA's on the floor during the time residents are receiving HS cares. In addition there are two nurses on the floor during the evening shift. It is a concern to the DON that residents and families have the perception that staffing is not sufficient. We feel this perception is in direct correlation to the timely answering of call lights. DON will have the Activities Department Head review a note from the DON concerning staffing patterns and p quality plan to monitor timeliness of call light answering and to do random interviews with residents to see if their needs are being met in a timely manner at the Sunshine Club meeting on 7/23/14. DON will write an article addressing survey results and plan of correction and will include staffing levels in the quarterly Care Center newsletter which will be published in August 2014.</p>	07/18/14

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F 246	Continued From page 3 Director of Nursing (DON), the concerns/complaints about the call lights not being answered timely and the lights being turned off without staff providing assistance were discussed. She reported she had recently completed an audit on the call system since they had a computer system to track the times that lights were left on. The audit had revealed a few incidence where lights were a little long but not significant. The issue with staff turning off the call light and reporting they would be right back was not addressed during the audit. She was not currently aware of the residents' concerns about not getting call lights answered.	F 246		
F 280 SS=E	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.	F 280	It is accepted that residents care plans should be updated with each MDS, and when there is a change in resident condition and or a change in the resident's plan of care occurs. It is acknowledged that the care plans for resident #3, #9 and #11 were not reflective of the resident current plan of care and condition. In addition it was acknowledged that the current care plan system was cumbersome to read and the in room care plans did not always match to the computer care plan. Furthermore it is acknowledged that although the restorative nurse (DON) does write a monthly restorative nursing review of the plan of care, completes the quarterly and PRN restorative evaluation including writing all restorative nursing diagnosis, restorative goals and interventions, she did not review the care plan after the data was entered. From this point forward the restorative nurse (currently the DON) will enter the nursing diagnosis and review all the data entered on the restorative plan of care. This can be verified by running a care plan audit.	07/18/14

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F 280	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, it was determined that the facility failed to update residents' care plans as their needs changed for three of 12 sample residents (#3, #9, and #11) . The findings included:</p> <p>1. Medical record review for sample resident #3 evidenced that the resident was admitted on 1/9/14 with diagnoses documented on the admission Minimum Data Set (MDS) assessment as anemia, hypertension, arthritis, anxiety disorder, depression, neuropathy, foot ulcer, and cataracts.</p> <p>a. Review of the resident's 1/16/14 admission and 4/17/14 quarterly MDS assessments revealed that the resident ate independently with no staff support (1/16/14) and required extensive assistance by one staff member (4/17/14). No weight loss or nutritional approaches were noted on either assessment. The resident's weights were 170 and 172 pounds, respectively.</p> <p>b. Review of the resident's "Resident Profile" [which was described by the Director of Nursing (DON) as the Certified Nurse Aides' (CNAs) care plan] evidenced the following care issues which were not current for the resident due to a change in his condition:</p> <p>i). Review of the facility's nutrition documentation revealed that the resident experienced a weight loss (from 3/24/14 to 6/17/14) of 20.5 pounds or 12% in three months and needed extensive to total assistance when eating . Refer to F325 for details.</p>	F 280	<p>During the week of July 13 - 18 the care plans for residents #3, #9 and #11 (residents cited in this deficiency) and residents #2, #4, #7, #9, #11, #13 and #14 (residents cited in other deficiencies) were reviewed and updated. Resident #5 was not updates because she has been admitted to Avera Behavioral Health for evaluation and treatment on July 3, 2014. Each department including the restorative nurse reviewed their section of the care plans. (See F 325 and F 323 POC) At this time all the old entries were removed from the care plan so only current information is visible when viewing a resident care plan. Deleted data can be retrieved by running a care plan audit for desired time frame. In addition all the mini care plans have been removed from resident rooms. All residents who have had their care plan updated no longer will have a mini care plan. Staff who would like to view the care plan may view the plan of care on the computer, or they can also access specific resident care areas through the bubble on one of three interventions. The information in the bubbles is linked directly to the care plan so if the care changes in the care plan it will also change in the bubble. The ADL intervention will list each ADL separately and the resident specific interventions. The toileting plan intervention will list the resident specific interventions for toileting and the fall risk assessment will list all the resident specific interventions for fall prevention. Starting July 21, 2014 staff will update all care plans in this manner as their MDS assessment is completed. All care plans will be updated by October 21, 2014. In an effort to ensure care plans are updated in a timely manner, starting in August 2014, DON will review 10% of the residents care plan monthly to ensure the accurately reflect the residents current health status. DON will target resident who had an illness, fall with injury and weight loss. . DON will report compliance on the care center dashboard monthly beginning August, 2014 and report to the Platte Health Center Quality Team monthly beginning in October 2014.</p>	07/18/14

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F 280	<p>Continued From page 5</p> <p>The CNA care plan noted the resident was on a regular diet, feeds self with no assistance or support, is to be offered a supplement/snack in the morning, sits in a chair for meals, and has upper and lower dentures. There was a comment to "cut foods for him".</p> <p>ii). On the CNA care plan for Ambulation, the resident was listed to need extensive assistance by one or two staff members to ambulate, using a walker and gait belt, occasionally hand in hand, and full weight bearing. Observation during the survey and interviews with the staff and a family member verified that the resident no longer ambulates and he uses a wheelchair.</p> <p>iii). On this care plan under Restorative Care, the resident was listed as ambulating 4 - 6 times a week, using a gait belt. On 6/18/14 in the morning, interview with the restorative nurse aide (C) evidenced that the resident does not ambulate and has not for some time. On 6/18/14 in the afternoon in an interview with the DON, she remarked the restorative care plan would be changed when therapy did the resident's quarterly assessment and that nursing does not change those plans even if the resident's status changes.</p> <p>c. Review of the resident's plan of care revealed that it was not updated. The following were examples:</p> <p>i). For Restorative Nursing Therapy, the interventions included ambulate 4 - 6 times a week with roller walker, gait belt, and extensive assist X 2.</p> <p>ii). For Impaired Nutritional Status, the plan of</p>	F 280		

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F 280	<p>Continued From page 6</p> <p>care listed interventions of :</p> <p>"Offer between meal snacks - 4 oz ensure clear @ lunch and a.m. and a.m. snack and magic cup @ h.s. snack. 5/27/14 added 8 oz Juven Brkf and supper."</p> <p>There was no evidence that the resident had his weight loss or increased need for assistance addressed on the care plan.</p> <p>Refer to F311 for meal observations.</p> <p>2. Record review for resident #9 revealed diagnoses that included anemia, urinary tract infections, arthritis, Alzheimer's , depression, chronic kidney disease, and atony of the bladder.</p> <p>a. Review of the resident's 2/1/14 annual and 5/4/14 quarterly MDS assessments evidenced that the resident was independent with no staff support for bed mobility, walking in and out of room, and locomotion on and off the unit. The resident's cognitive status was assessed to be moderately impaired (score 8 on the BIMS in 2/14) and severely impaired (score of 3 on the BIMS in 5/14).</p> <p>b. On 6/18/14 at 9:30 AM, this resident was observed in the dining room with several stitches on the top of his head. When nurse (G) was questioned about the resident's injury, she said that the resident fell and hit his head on 6/17/14.</p> <p>c. Review of the documentation for the resident's falls evidenced the falls with injuries on 6/17/14, 5/14/14, 1/26/14, and 10/26/13 and falls without injuries on 5/28/14, 5/16/14 (no details to know if injury or not), and 9/2/13. For details about the falls refer to F323.</p>	F 280			

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F 280	Continued From page 7 d. Review of the resident's plan of care evidenced a Problem "High Risk for Falls" with Interventions dated back to his admission date of 2/2011. There were no changes to the interventions even though this resident's falls increased and involved injuries, including head injuries. 3. . Record review for resident #11 revealed diagnoses that included thyroid disease, arthritis, osteoporosis, non-Alzheimer's dementia, anxiety, and depression. a. Review of the resident's 3/30/14 annual MDS assessment revealed that the resident required extensive assistance by one or two staff members for bed mobility, transfer, locomotion on and off the unit, dressing, toilet use, personal hygiene, and bathing. The resident was assessed to have a history of falls and was taking antipsychotic and antidepressant medications. Additionally, the resident was assessed to be severely cognitively impaired with a BIMS score of 4. b. Review of the documentation for the resident's falls evidenced falls on 5/27/14, 5/21/14, 5/18/14, 4/7/14, 4/2/14, 3/31/14 (head bumped), 3/28/14, 3/16/14, 1/17/14, 12/21/13, and 12/18/13. For details about the falls refer to F323. c. Review of the resident's plan of care evidenced a Problem "High Risk for Falls" with Interventions dated back to her admission date of 8/2011. The only changes made in 2013 related to discontinuing the use of positioning devices and in 2014 to discontinuing the use of the Wanderguard and then starting it again. A Wanderguard would not prevent falls unless the	F 280			

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F 280	Continued From page 8 resident was eloping and falling outside the restricted area. There were no intervention changes related directly to resident's increased falling.	F 280		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, it was determined that the facility failed to provide timely meal assistance, including cueing and supervision, to one of 12 sample residents (#11) and two supplemental residents (#13 and #14) in order to maintain or improve their abilities to eat. These residents were facility assessed and were observed to be able to feed themselves. The findings included: 1. On 6/17/14 observations during the evening meal identified concerns with three residents sitting at the same table. The residents were served their food at 6:00 PM. The residents were not provide cueing and assistance with eating until 6:23 PM. The following issues were identified: a. Resident #11 was seated in a wheelchair backed away from the table. The resident had her eyes closed and appeared to be asleep when her food was served. Staff did tell the resident her food was on the table. The resident was observed trying to feed herself and she would lean forward	F 311	It is recognized that we need to be supplying all residents' timely assistance and supervision at meals, in order to maintain or improve their ability to eat. Resident #11 has been moved to an assist table where she can receive added supervision/cueing during meals. Resident #13 and #14 will remain @ the current table, as their intakes @ meals have been adequate and weights are stable the last month. Resident #13 meal intakes have been 50-100% and wt has been stable, (wt on June 19-114# current wt on July 10-113.8#) , Resident #14 meal intakes have been 75-100%, (wt on June 17-129# current wt on July 8-128#). Staff from Dietary and activities will give cueing/assistance to resident #13 and #14 when they deliver their tray to them. Staff will also continue to cue these residents and the other residents at this table as they deliver trays to neighboring residents. The CNA to finish feeding other residents first, will move to this table to see if any of the residents are in need of assist/cueing in order to finish their meal. Staff will ask residents @ the five non-assist tables to see if there is anything they would like more of or if anyone needs assistances with something. Staff will offer this during each meal.	07/18/14

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F 311	Continued From page 9 in an attempt to get the food into her mouth. The resident was noted to spill food on her lap and then try to retrieve it. Staff did not cue or assist the resident with positioning at the table to enhance the resident's ability to eat by herself. b. Resident #14 was seated in a wheelchair. The resident did attempt to feed herself when food was served. The resident was not positioned up to the table. She was noted to spill food after taking a few bites. The resident then stopped eating and did not eat again until staff cued her approximately 20 minutes later. c. Resident #13 was observed to eat several bites of food then stop and watch the other residents. The resident did not eat again until she was cued by staff at 6:23 PM. d. On 6/17/14 at 6:30 PM, in an interview with the CDM (Certified Dietary Manger) (D) related to the lack of timely assistance, she confirmed the residents identified had cognitive impairment and did need cueing assistance. 2. On 6/18/14 during the group interview, seven residents were in attendance. There were six residents who reported concerns with assistance in the dining room. The residents reported they were aware some residents needed to be fed and understood other residents needing help. After the trays were served, the residents reported it was difficult to get assistance, like getting seconds or more to drink.	F 311	Education for RN/CNA's was held on July 15 & 16; dietary education will be completed by July 18 th . See attached signature sheets with summary. Starting August 1, the CDM will do random audits weekly for 1 month and monthly for 11 months. To ensure that staff is giving residents the added assist/cueing that is needed and that staff is asking the non-assist table about extras or if any needed assistance is required. CDM will report compliance on the Dietary dashboard monthly and report to the Platte Health Center Quality team quarterly, beginning In September 2014.	07/18/14	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323			

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F 323	<p>Continued From page 10</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and family and staff interview, it was determined that the facility failed to adequately assess, care plan, and supervise four of 12 sample residents (#3, #5, #9, and #11) who were at risk for falls. The findings included:</p> <p>1. Medical record review for sample resident #3 evidenced that the resident was admitted on 1/9/14 with diagnoses documented on the admission Minimum Data Set (MDS) assessment as anemia, hypertension, arthritis, anxiety disorder, depression, neuropathy, foot ulcer, and cataracts.</p> <p>a. Review of the resident's 1/16/14 admission and 4/17/14 quarterly MDS assessments revealed that the resident required extensive assistance by one or two staff members for bed mobility, transfer, walk in and out of room, locomotion on and off the unit, dressing, eating, toilet use, personal hygiene, and bathing. The assessments evidenced that the resident had a history of falls before admission.</p> <p>b. On 6/18/14 in the afternoon, in a confidential family interview, the family member expressed concerns about her family member being put in the bathroom (using the sit to stand lift) and then</p>	F 323	<p>It is recognized that resident have the right to be in and environment that is free of accident hazards as possible and each resident receives adequate supervision and assistance devices to prevent accidents. It is acknowledged that the facility failed to assess, care plan and supervise residents #3, #5, #9 and #11 who were at risk for falls. During the week of July 13 - 18 the care plans for residents #3, #9 and #11 (residents cited in this deficiency) and residents #2, #4, #7, #13 and #14 (residents cited in other deficiencies) were reviewed and updated (see F 280). Resident #5 was not updated because she has been admitted to Avera Behavioral Health for evaluation and treatment. Resident #3 was placed on supervised toileting during the survey. On July 3, 2014 he was placed on hospice care per family request. He has had no more falls. Resident #9 is now ambulated to and from his room with staff assist. He does ambulate independently in his room with FWW. He has had no more falls. Resident #11 was noted to have shingles at the time of the falls mentioned in survey. She has had no falls since recovering from her shingles. She was ill with UTI on 7/9/14 and staff noted increased fatigued and provided interventions to accommodate fatigue so resident remained accident free.</p> <p>On July 15 and 16, 2014 all staff were educated on fall up and prevention. Starting on July 21, 2014, nurses / CNA educated to be alert to increased fall risk and provide extra supervision and support to resident after psychotropic and pain medication changes, illness, and PRN pain and behavioral medications. After every fall the nurse and with input from CNA's and any ancillary staff that was present during fall investigate the cause of the fall. The nurses must utilize this information and implement appropriate interventions to prevent further falls. Areas to assess include are trends in recent falls, does the resident have signs or symptoms of UTI or other illness, is having pain or had a recent pain medication, does the resident need to use the toilet, and did the resident have change in or PRN psychotropic medication? Interventions will be placed in the fall follow up intervention. The Patient Care Coordinator or select nurse will review all falls and implemented interventions. She will review current care plan and may revise and or add additional interventions and document interventions in the fall follow up in the resident care plan.</p>	07/18/14

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F 323	<p>Continued From page 11</p> <p>being left alone on the lift. She indicated that she had seen the resident stand up using the lift while alone in the bathroom. According to the family member, the resident has experienced two falls since admission in January. She said that one was in the hallway and she did not know what happened. The other occurred when one staff member was transferring the resident out of the wheelchair. The family member thought the brakes were not locked.</p> <p>c. On 6/19/14 at 8:45 AM, in an interview with the Administrator and Director of Nursing (DON), the DON was asked about resident #3's falls. She said that the staff are using the sit to stand lift for the resident's transfers and that he is not able to pull himself to a standing position alone. She verified that she was not aware of anytime when he stood up while left unattended. The DON confirmed that the lift does not replace staff. She revealed the resident had two falls since admission (on 1/9/14 and 4/17/14). The DON was requested to provide copies of the incident reports for the resident's falls.</p> <p>d. Review of the resident's Resident Profile [Certified Nurse Aide (CNA) care plan] evidenced that the resident required extensive assistance by one to two staff members and two staff for manual transfers (without a list). In the "Other" section of transfer it was noted "Should not transfer alone".</p> <p>2. Record review for resident #5 revealed that the resident's diagnoses included Alzheimer's dementia, dementia with behavioral disturbances, hypothyroidism, seizures, and history of falls.</p> <p>a. Review of the resident's 2/7/14 quarterly and</p>	F 323	<p>Beginning in August 2014 DON or select nurse will audit 50% of resident falls to ensure appropriate interventions were implemented and documented in plan of care. DON will report compliance on the care center dashboard monthly beginning August, 2014 and report to the Platte Health Center Quality Team monthly beginning in October 2014.</p> <p>June 14 - June 17, 2014 DON, PCC, SSD and CNA staff reviewed toileting plans for all residents assessed as severely impaired on the MDS. These residents and any residents assessed as severely impaired from this point on will not be left alone while toileted. In addition all residents with a BIMS less the 7 but assessed by staff and documented as moderately impaired on the MDS, had their toileting plans assessed and changed if at risk for falling in bathroom or getting injured in a standing lift. Residents at risk were changed to supervised toileting. On June 15 & 16 staff were educated on risk for injury to resident while being left alone on standing lift. Input from staff was solicited and they were informed of changes in resident toileting Plans. Staff is instructed to inform PCC / DON or charge nurse if feel any resident is a risk during toileting Changes to toileting plans made after staff meetings, were communicated through taped nursing report and a written note in communication book. Subsequent changes will be communicated in same manner. PCC updated toileting plans in care plan. Beginning August 2014, SSD will bring a list of all residents with BIMS less than 8 and assessed as moderately impaired on the MDS to monthly care center council meeting. Care Center council will review and edit interventions to ensure resident safety and appropriate use of mechanical lifts. Any changes will be communicated through taped nursing report and communication book. PCC will update affected residents care plan. DON will report compliance on the care center dashboard monthly beginning August, 2014 and report to the Platte Health Center Quality Team monthly beginning in October 2014.</p>	07/18/14	

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F 323	<p>Continued From page 12</p> <p>5/8/14 annual MDS assessments revealed that the resident required extensive assistance by two staff members for bed mobility, transfer, walk in and out of room, locomotion on and off the unit, dressing, toilet use, and bathing and required total assistance with eating and personal hygiene by one staff member. The assessments evidenced that the resident had a history of falls before admission.</p> <p>b. Review of the resident's documentation for falls evidenced that the resident has fallen thirteen times since the beginning of the year (1/1/14 to 6/10/14).</p> <p>c. Review of the resident's Plan of Care revealed a Problem of "High Risk for Falls" with numerous Interventions that were initiated prior to 1/1/14. Since the beginning of the year, the only dated new approaches were medication changes. No further documentation of interventions in an attempt to prevent additional resident falls.</p> <p>d. Review of the resident's Resident Profile (CNA plan of care) evidenced that the resident was a fall risk with occasional unsteady gait, poor balance, and impaired mobility. This plan indicated that the resident used a wheelchair for long distance. The resident was to wear gripper socks on at bedtime and during the night to prevent falls and to use a body pillow.</p> <p>e. Observations during the survey revealed that the resident was independently ambulating and was not utilizing a wheelchair (as directed in the CNA plan of care. Nor was the resident assisted by two staff for ambulation as assessed in the MDS assessments.</p>	F 323			

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F 323	<p>Continued From page 13</p> <p>3. Record review for resident #9 revealed diagnoses that included anemia, urinary tract infections, arthritis, Alzheimer's , depression, chronic kidney disease, and atony of the bladder.</p> <p>a. Review of the resident's 2/1/14 annual and 5/4/14 quarterly MDS assessments evidenced that the resident was independent with no staff support for bed mobility, walking in and out of room, and locomotion on and off the unit. The resident's cognitive status was assessed to be moderately impaired (score 8 on the BIMS in 2/14) and severely impaired (score of 3 on the BIMS in 5/14).</p> <p>b. On 6/18/14 at 9:30 AM, this resident was observed in the dining room with several stitches on the top of his head. When nurse (G) was questioned about the resident's injury, she said that the resident fell and hit his head on 6/17/14.</p> <p>c. Review of the documentation for the resident's falls evidenced the following:</p> <p>6/17/14 20:57 (8:57 PM) - "fall in doorway of room 9. hit his head on the doorway.... pt. was unresponsive and breathing deep, after sitting pt up he came to but didn't remember falling ... blood coming from head --> to ER (emergency room). The nurse's recommendation - walk with resident - make sure call light is in reach.</p> <p>5/28/14 13:45 (1:45 PM) - "Res lost balance when pulling pants up after nurse did cath for resident - no injuries." The nurse's recommendation - assist res with pulling up pants."</p>	F 323			

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F 323	<p>Continued From page 14</p> <p>5/16/14 17:50 (no details found)</p> <p>5/14/14 0450 (4:50 AM) - "rolled out of bed - skin tear midforehead, left side of nose, & left elbow - hit head on trash can or nob on dresser ... oriented x 3. The nurse recommendation - to use call light. Remind to use call light, bed in low position."</p> <p>1/14/14 2200 (10:00 PM) - "fall with injury - bump right side forehead ... right elbow with skin tear with bleeding"</p> <p>10/26/13 - "skin tear left elbow"</p> <p>9/2/13 - (fall) - no injuries.</p> <p>d. Review of the resident's plan of care evidenced a Problem "High Risk for Falls" with Interventions dated back to his admission date of 2/2011.</p> <p>There were no changes to the interventions even though this resident's falls increased and involved injuries, including head injuries.</p> <p>4. Record review for resident #11 revealed diagnoses that included thyroid disease, arthritis, osteoporosis, non-Alzheimer's dementia, anxiety, and depression.</p> <p>a. Review of the resident's 3/30/14 annual MDS assessment revealed that the resident required extensive assistance by one or two staff members for bed mobility, transfer, locomotion on and off the unit, dressing, toilet use, personal hygiene, and bathing. The resident was assessed to have a history of falls and was taking antipsychotic and antidepressant medications. Additionally, the resident was assessed to be</p>	F 323		

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F 323	<p>Continued From page 15</p> <p>severely cognitively impaired with a BIMS score of 4.</p> <p>b. Review of the documentation for the resident's falls evidenced the following:</p> <p>5/27/14 2:30 AM - "on floor mat, bed in low position - denies pain". Nurse recommendation - "continue to check on resident frequently.. if notice she is getting restless, reposition her.."</p> <p>5/21/14 1:26 AM - "on floor by chair, Staff put her in recliner (after toileting and res refusal to lay in bed). Resident slid out of recliner onto floor, states she was trying to go to the bathroom - denies pain, no injuries, Res' up at nurses station to monitor." Nurse recommendations - "Take res on schedule to bathroom, is restless during night get up in wheelchair to be monitored more closely."</p> <p>5/18/14 3:30 AM - "on floor in room, sitting on buttocks - put in wheelchair --> to nurses station . No injuries".</p> <p>4/7/14 2:43 AM - "two staff assist on res et res on lift et taking her out of bathroom - res lifted arms up and started to slide out of lift so staff lowered to floor." Nurse recommendation - "monitor res closely while in lift ... follow care plan."</p> <p>4/2/14 1:20 AM - "res in wheelchair at nurses station - CNA found her on floor.." Nurse recommendation - "many need alarm - rash (?affect sleep)</p> <p>3/31/14 4:16 AM - "on floor by other bed - trying</p>	F 323			

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F 323	<p>Continued From page 16</p> <p>to go to bathroom - bumped her head and must have been 'knocked out' - no visible injuries.." Nurse recommendation - "re-enforce use of call light.."</p> <p>3/28/14 23:30 (11:30 PM) - "on floor on mat - low position - body pillow in place - no injuries."</p> <p>3/16/14 00:06 (12:06 AM) - "on floor by bed - attend off - trying to put shoes on" Nurse recommendation - "reminded res how to use call light - remind staff to stick to toileting schedule".</p> <p>1/17/14 3:30 AM - "on floor - attend off - combative... To wheelchair - assist of 3 and gait belt - chased staff - tried to hit, kick, and bite".</p> <p>Additional falls on 12/21/13 from recliner, 12/18/13 out of bed, 12/18/13 from recliner.</p> <p>4/17/13 - "resident fell from commode - CNA walked out of bathroom...."</p> <p>c. Review of the resident's plan of care evidenced a Problem "High Risk for Falls" with Interventions dated back to her admission date of 8/2011. There were no changes to the interventions which addressed the resident's increased number of falls. A Wanderguard was added, but this did not relate to fall prevention.</p> <p>5. On 6/18/14 during an interview with the DON, she confirmed she was aware of the practice of leaving residents on the toilet unattended with the EZ stand lift. The concern with Resident #3 being left unattended was discussed. The resident was identified as a high fall risk, cognitively impaired</p>	F 323			

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F 323	<p>Continued From page 17</p> <p>with BIMS of 3 (0-7 severe cognitive impairment). Staff leaving this resident unattended on the toilet placed this resident at a potential risk for falls and or injury. It also showed that the facility was not following the manufacturer's instruction with the use of the lift and FDA guidelines for safety of "DO NOT Leave patient unattended while in lift."</p> <p>6. On 6/18/14 the DON provided a copy on the Operation's Instructions for the "EZ WAY Stand" lift currently being used in the facility. The instructions included:</p> <p>-"The EZ way stand was designed specifically for toileting and changing briefs of patients. The EZ Way stand can also be used for transferring the patient from chair, wheelchair, toilet or bed and can be used for ambulation. As patients do vary in size, shape, weight and temperament, these conditions must be taken into consideration when deciding if the EZ Way stand is suitable for their needs. Patients should be able to bear some weight, have upper body strength(i.e. be able to sit on the side of the bed unattended), and be able to follow simple commands. If a patient does not meet each of these three criteria, the EZ Lift total body lift must be used.</p> <p>-Safety Notes: The EZ Way stand was designed to be operated by ONE caregiver. However, depending on the situation, facility policy and patients' condition, TWO caregivers may be necessary."</p> <p>REFERENCE: FDA (Food and Drug Administration) Patient Safety Guide:</p> <p>"Prepare Environment: Determine number of</p>	F 323		

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F 323	Continued From page 18 caregivers needed; Most lifts require two or more caregivers to safely operate lifts and handle patient. DO NOT Leave patient unattended while in lift. NEVER Keep suspended in sling for more than a few minutes ... Know your lift: Patient lifts are designed to lift and transfer patients from one place to another (e.g., from bed to bath, chair to stretcher) ... These medical devices provide many benefits, including reduced risk of injury to patients and caregivers when properly used. However, improper use of patient lifts can pose significant public health risks. Patient falls from these devices have resulted in severe patient injuries including head traumas, fractures, and deaths."	F 323		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, it was determined that the facility failed	F 325	It is recognized that we failed to implement interventions to prevent unplanned wt loss in a timely manner on resident #3, #2 and #7, and to modify their intervention to reflect the continued weight loss that the residents experienced. We also failed to consistently monitor the resident's supplement/snack intakes on a regular basis. Starting July 14, 2014 dietary staff will no longer record the supplement/snack intakes on the feeding record in the EMR. Staff will now document intakes in the snack/nutrition supplement-LTC intervention in the EMR. Each supplement/snack will be marked as to time given, what kind was given, what % was consumed and how many ml the resident drank. Staff will be able to view the kind and amount of supplement/snacks that was offered, in the bubble of the snack/nutrition supplement-LTC intervention. If staff or family request an additional supplement/snack for a resident who has poor intakes they need to let staff that are doing the charting know so they can add the additional ml when charting. Perimeter times will be put in place on each supplement/snack to ensure that all supplement/snacks have been recorded by staff in the EMR.	07/18/14

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F 325	<p>Continued From page 19</p> <p>to assess and implement interventions to prevent unplanned weight loss for three of 12 sample residents (#3, #2 and #7). The facility failed to consistently monitor supplement/snack intake and to implement nutritional interventions timely to address the residents' ongoing weight loss. As these residents continued to lose weight, the approaches were not modified to address the ongoing weight loss. The findings included:</p> <p>1. Medical record review for sample resident #3 evidenced that the resident was admitted on 1/9/14 with diagnoses documented on the admission Minimum Data Set (MDS) assessment as anemia, hypertension, arthritis, anxiety disorder, depression, neuropathy, foot ulcer, and cataracts.</p> <p>a. Review of the resident's 1/16/14 admission and 4/17/14 quarterly MDS assessments revealed that the resident ate independently with no staff support (1/16/14) and required extensive assistance by one staff member (4/17/14). No weight loss or nutritional approaches were noted on either assessment. The resident's weights were 170 and 172 pounds, respectively.</p> <p>b. Review of the facility's weekly weight tracking documentation listed the following weights in pounds:</p> <p>3/24/14 - 177.5 3/31/14 - 176 4/7/14 - 174 4/14/14 - 171.5 4/21/14 - 170 4/28/14 - 168 5/5/14 - 162.5 5/6/14 - 164.5</p>	F 325	<p>If staff find that the person before them missed charting a snack/supplement, they need to remind that staff member to go back and do their charting or inform their supervisor so charting can be completed in a timely manner.</p> <p>It is all staff responsibility to ensure that residents maintain wt unless unavoidable. We will monitor all residents for wt loss and those who are found to be a risk or have had a significant loss, will be assessed to see if they need to be put on a fortified food/hi calorie program-(per policy), recipes available for staff use are fortified oatmeal, power potatoes and super soup. CDM will do a weekly check to see if there are any residents who have had a significant loss in the last 14 days, 21 days, 30 days, 90 days or 180 days. This report will be printed off and given to nursing to report to staff twice daily through taped report, it will also be available in the kitchen for dietary staff to view. Nurses will check resident's weekly weight when they put them in the EMR to ensure they are stable, if they find a significant change they will ask staff for a re-weight the next day, if weight is still significantly different they will notify the MD and the CDM, for review. When residents are identified as having a significant weight change the RD, CDM or MD will put what they feel are the appropriate interventions in place to help prevent any further weight loss. These interventions could include, supplements/snacks, hi calorie foods/fortified foods, change in textures, modified diets and more assistance/supervision at meals. These interventions will be modified in the care plan and on the resident's meal sheet/meal cards, as the residents weights stabilize or there condition improves/declines. Care plans for resident #2 and #7 have been modified to reflect the current interventions that are in place to try and prevent any further weight loss. Resident #3 is now on end of life/hospice care per family's request. Prior to this family had requested we try and feed him in his room; intakes did not improve with this intervention, for staff or family. Family then requested we stop all trays/supplements unless they ask for something; his care plan has been updated to reflect this change.</p>	07/18/14

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F 325	<p>Continued From page 20</p> <p>5/12/14 - 163.5 5/19/14 - 165 5/26/14 - 162 6/2/14 - 164 6/9/14 - 162 6/17/14 - 157.</p> <p>The resident's weight loss from 3/24/14 to 6/17/14 was 20.5 pounds or 12% in three months.</p> <p>c. Review of all of the resident's dietary notes, provided by the Certified Dietary Manager (CDM) (D), evidenced the following notes:</p> <p>On 1/20/14, the Registered Dietitian (RD) (A) assessed the resident for his admission assessment. She recommended "offering an additional 1 oz protein @ meals to meet protein needs for wound healing. Will continue to monitor intake, weight, skin integrity."</p> <p>On 1/20/14, the CDM (D) assessed the resident for his admission assessment. She noted "RD to assess later this week, will question if she would like Juven started daily, does not like to drink juice @ this time. Continue to monitor for nutritional intervention (sic)."</p> <p>On 1/24/14, the RD (A)'s comment was "Stage III ulcer to R big toe is healing, ... continue to offer 1 oz. extra protein @ meals until healed."</p> <p>On 2/26/14, the RD (A) recommended "continuing to offer an additional 1 oz protein @ meals to meet protein needs for wound healing. Will continue to monitor intake, weight, skin integrity."</p>	F 325	<p>On July 23, 2014-Dietary staff will be educated on the new fortified/hi calorie Foods policy, the new fortified food recipes, and on the importance of looking at the most recent weight loss report that will be posted in the kitchen. All Dietary staff that will be charting in the EMR on the Snack/nutrition supplement-LTC intervention have received one on one training in the past week. Nursing and Activity staff was educated by the DON on the importance of weight loss and the snack supplement charting on July 15 & 16. Starting August 1, the CDM will do weekly audits for 1 month and monthly for 11months, to ensure the snacks/supplements are being charted correctly and in a timely manner. CDM will do random monthly checks on a resident who was found to have a significant weight change, to ensure the interventions that were implemented by RD/MD/CDM, are being followed by staff. CDM will also check to see that the appropriate staff, are modifying/updating these interventions to reflect any changes that may have occurred in the resident's health/weight or if they have had any changes in their ADL performances. CDM will report compliance on the dietary dashboard monthly and report to the Platte Health Center quality team quarterly, beginning in September 2014.</p>	07/23/14

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F 325	<p>Continued From page 21</p> <p>On 3/26/14, the RD (A) recommended "continuing to offer an additional 1 oz protein @ meals to meet protein needs for wound healing. Will continue to monitor intake, weight, skin integrity."</p> <p>On 4/17/14, the RD (B)'s documentation was entitled "nutrition Review d/t (due to) open area. is offered 1 oz extra protein at each meal.....Not taking Juven at this time as resident doesn't like to drink juice.."</p> <p>On 4/18/14, the CDM (D)'s quarterly assessment revealed a weight loss of 2% in 30 days, "...he has been needing extensive assist (sic) ... continue to monitor for nutritional intervention (sic)." (Note: These were the first dietary notations of weight loss and of the need for extensive assistance with eating.)</p> <p>On 5/22/14, the RD (B) noted a weight loss of 3% in 30 days and 5% in 90 days, a need for extensive assistance with eating, and added a recommendation for Juven 2x/day until toe is healed.</p> <p>On 6/16/14, the RD (B) noted a weight loss of 5% in 30 days and 11% in 90 days, a total dependence for eating, and "Meal intakes remain less than desired. Continues to lose weight due to insufficient oral intake. ... Is accepting a fair amt of the Juven. ... Appropriate interventions are in place. Continue to monitor."</p> <p>d. Review of the resident's physician orders revealed an order for a regular diet. AM and HS snacks and weight weekly were listed on the order sheet. There were no physician orders that included the RD's recommendations.</p>	F 325		

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F 325	Continued From page 22 e. Review of the resident's dietary sheet which the CDM (D) confirmed was the form used by the dietary staff when serving the resident's meal revealed : Regular diet and regular consistency Beverages to include: Breakfast - Juven 8 oz; Dinner (noon meal) - Ensure Clear 4 oz; Supper (evening meal) - Juven 8 oz. Snacks: A.M. Ensure Clear 4 oz; H.S. (bedtime) Magic Cup. There was no indication that 1 oz of extra protein was to be added to each of the resident's meals or that the meal was being fortified with extra calories (such as cereal with added brown sugar, milk powder, or butter, extra gravy, extra butter, etc.). f. Review of the documentation showing the resident's meal, fluid, and supplement intakes for the months of May and June, 2014 evidenced the supplements were not consistently documented. The following were examples of incomplete or missing documentation on these records: 6/15/14 at 1200 (noon) - no fluid or supplement 6/14/14 at 9:46 AM - no notation 6/10/14 at 18:53 (6:53 PM), 6/7/14 at 9:54 AM, 6/6/14 at 9:17 AM, 6/4/14 at 9:25 AM, 5/30/14 at 18:43 (6:43 PM), 5/29/14 at 13:15 (1:15 PM), 5/27/14 at 9:26 AM, 5/26/14 at 9:27 AM, 5/25/14 at 18:46 (6:46 PM), and 5/25/14 at 10:12 AM - no supplement documentation. The failure to document the amount or actual	F 325		

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F 325	<p>Continued From page 23</p> <p>supplement consumed by the resident limited the facility's ability to assess the effectiveness of the nutritional interventions. Additionally, there was no evidence to show that the supplements or other interventions were provided in response to the resident's weight loss.</p> <p>g. The manufacturer information for Juven indicated that it contained "key nutrients to support tissue building, helps build new tissue when your body needs it the most - after injury and surgery". Review of the nutritional information which was printed on the Juven box evidenced that it did not contain fruit juice and one packet was to be mixed with 8 to 10 oz of juice or water. Each packet provides 80 calories.</p> <p>h. Observation of the resident during meals included:</p> <p>1) During the evening meal on 6/17/14 revealed that the resident was seated at the table in a wheelchair. The resident was served at 6:03 PM. Staff then returned at 6:10 PM and sat down next to the resident to feed him. The staff made several attempts to give the resident bites of food. The resident refused and staff left the table. At 6:16 PM the staff returned to offer food and when resident refused to eat, staff left the table. No other food alternates were offered and the staff did not attempt to feed the resident again during this meal observation.</p> <p>2) During the breakfast meal on 6/18/14 at 8:10 AM, staff (CNA F) was noted to be sitting next to the resident attempting to give the resident a bite of his pancake. The resident was noted to spit out his food and then asked the CNA for his teeth. The CNA was then observed to use</p>	F 325			

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F 325	<p>Continued From page 24</p> <p>a hand held device to call another staff. The CNA then asked, "I am feeding (resident) do you know where his teeth are?" The responder then reported, "His teeth are still at the dentist." Staff F then told the resident his teeth were broken and at the dentist's office. The CNA then reported to the surveyor she would get him some hot cereal which would be easier for the resident to eat since his teeth were gone. The resident was given hot cereal and was noted to consume all of it except a few bites. The staff also verified she was not aware of the hot cereal being fortified.</p> <p>i. On 6/18/14 at 10:20 AM in an interview with the CDM (D), she stated that they do not have recipes to use to prepare fortified foods. She indicated that they can add sugar, jelly, and gravy.</p> <p>j. On 6/19/14 at 10:00 AM in an interview with the CDM (D), she commented that they fortify eggs by adding cheese, milk, and butter which would add 260 calories and cereal by adding butter, 1/2 & 1/2, and brown sugar which would add 350 calories. It was not clear how the calories were calculated without having recipes to follow when fortifying. There was no evidence to show that the resident was receiving any fortified foods with his meals.</p> <p>k. On 6/19/14 at 10:40 AM in a phone interview with the RD (B) in the presence of the CDM (D), the RD (B) verified that she had set a weight goal of 160 - 170 pounds for the resident and that the resident's supplement intakes were documented on the computer for her review. She confirmed that the resident's weight loss was not addressed as he had been at the goal she established.</p>	F 325			

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F 325	<p>Continued From page 25</p> <p>I. On 6/18/14 at 4:50 PM, in an interview with a family member, the person stated that the resident gets some help to eat sometimes, not enough time is spent trying to assist him. She indicated that the resident is not offered fluids between meals. The family member said that if the resident could be allowed to eat in his room where it was quieter, he would eat better. The family member indicated that in the past she assisted the resident to eat, but the facility did not want her to assist him and did not allow residents to eat in their rooms unless they were pretty sick. The family member was unsure if she had spoken to the RD about the resident.</p> <p>Additionally, the family member revealed that the resident's teeth were being repaired so he was not able to chew some of the foods which were provided to him. Based on review of the RD and CDM's notes and the dietary staff's worksheets, there was no evidence to show that they were aware that the resident currently had no dentures nor was there any documentation to show an alteration in the texture of the food.</p> <p>2. Record review for resident #2 revealed that the resident had diagnoses that included dementia secondary to motor vehicle accident (mva), stroke, history of cancer, hypertension, and history of falls.</p> <p>a. Review of the resident's 2/6/14 annual and 5/7/14 quarterly MDS assessments evidenced the resident required supervision but no support for eating, had experienced non-physician prescribed weight loss on the 2/6/14 assessment, and no nutritional approaches were identified.</p> <p>Review of the resident's MDS documentation</p>	F 325		

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F 325	<p>Continued From page 26</p> <p>related to the use of diuretics (on the assessments done in 2/16/13, 11/12/13, and 8/10/13) revealed that no diuretics were in use).</p> <p>b. Review of the facility's weekly weight tracking documentation listed the following weights in pounds:</p> <p>10/29/13 - 193.5 11/5/13 - 191 11/12/13 - 187 11/19/13 - 185.5 11/26/13 - 186.5 12/3/13 - 183 12/10/13 - 181 12/17/13 - 181.5 12/24/13 - 183.5 12/31/13 - 182.5 1/7/14 - 179 1/14/14 - 172.5unchanged 4/29/14 - 174 5/6/14 - 173.5 5/13/14 - 173.5 5/20/14 - 172.5 5/27/14 - 173 6/3/14 - 170 6/4/14 - 167.8 6/10/14 - 167 6/17/14 - 167.</p> <p>The resident's weight loss from 12/24/13 to 6/17/14 was 16.5 pounds or 9% in six months and from 10/29/13 to 6/17/14 was 26.5 pounds or 13.7% in eight months.</p> <p>c. Review of all of the resident's dietary notes, provided by the CDM (D), evidenced the following notes:</p>	F 325		

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F 325	<p>Continued From page 27</p> <p>On 8/12/13, the CDM (E) assessed the resident for her quarterly assessment. She noted "Wt (weight) has gone up slightly in the last 6 months, need to watch her wt if continues to go up, RD suggest she lose wt...Continue to monitor for nutritional intervention." The resident was independent with eating.</p> <p>On 11/11/13, CDM (D) did a quarterly assessment. The notes show a 2% weight loss in 30 days and 90 days. She noted Wt has gone down slightly in the last 3 months, need to watch her wt if continues to go up (RD suggest she lose wt), has a good appetite. Continue to monitor for nutritional interventions." The resident was independent with eating.</p> <p>On 1/24/14, the RD (A) assessed the resident for a significant change. The resident's weight loss in 30 days was 6%, in 90 days 11%, and in 180 days 10%. The resident's feeding ability was assessed as requiring extensive assistance by one staff member. "Nursing has noted a decline in health status recently, ... poor appetite, recent pneumonia, consumin bites .. Will continue to offer supplement if resident consumes <50% of meal, continue to assit (sic) resident @ meals...."</p> <p>On 2/10/14, the CDM (D) assessed the resident for her annual assessment. The resident's weight loss in 30 days was 3%, in 90 days 9%, and in 180 days 11%. The resident's feeding ability was assessed as supervision with no setup/physical help. She noted "Wt has gone down 11% in the last 6 months (due to health decline). Appetite is improving as health improves, has not been getting ensure as intakes are usually greater than 50% @ this time. Continue to monitor for</p>	F 325			

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F 325	<p>Continued From page 28 nutritional interventions."</p> <p>On 2/26/14, the RD (A) assessed the resident for her annual assessment. The resident's weight loss in 90 days 10% and in 180 days 9%. The resident's feeding ability was assessed as supervision with no setup/physical help. She noted "... continue to assist resident @ meals. ... weight has stabilized the past month. Will continue with current interventions; monitor intake and weight..."</p> <p>On 3/26/14, the RD (A) assessed the resident for a significant weight change. The resident's weight loss in 30 days was 1%, in 90 days 7%, and in 180 days 11%. The resident's feeding ability was assessed as supervision with no setup/physical help. The RD recommended "staff continue to offer supplement if intakes are <50%... continue to assist resident @ meals.. Will continue with current interventions; monitor intake and weight..."</p> <p>On 5/8/14, the CDM (D) assessed the resident for a quarterly review. The resident's weight loss in 30 days was 0% (gain 1%), in 90 days 0% (gain 1%), and in 180 days 9%. The resident's feeding ability was assessed as supervision with no setup/physical help. The CDM noted "... Wt has gone down 9% in the last 6 months (due to health decline). Appetite is improving as health improves, has not been getting ensure as intakes are usually greater than 50% @ this time. Continue to monitor for nutritional interventions."</p> <p>d. Review of the resident's physician order sheet revealed a diet order for a regular diet with mechanical soft texture (ground meats) and weight weekly.</p>	F 325			

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F 325	Continued From page 29 e. Review of meal, fluid, and supplement intakes for the resident evidenced incomplete documentation. It was not clear how many times the resident was actually given the Ensure or even how many times she consumed less than 50% of her meals. f. On 6/19/14 at 10:40 AM in a phone interview with the RD (B) in the presence of the CDM (D), the RD (B) indicated the resident was receiving a high calorie diet. However, review of the form used by the dietary staff to serve the food, lacked any evidence that a high calorie diet was being provided to the resident. 3. Resident #7's medical record review revealed the resident was admitted to the facility on 5/18/11 with diagnoses which included: Alzheimer's dementia, COPD (chronic obstructive pulmonary disease), HTN (hypertension), DJD (degenerative joint disease), scoliosis, dorsal spine kyphosis, hypothyroidism, osteoporosis and history of low back pain. a. Review of the resident's "Monthly Weight Record" showed the resident's current weight for June 2014 as 134.5 pounds. It showed the resident's had a significant weight loss (18.5 pounds) from January 2014 with a weight of 153 pounds. b. Review of the resident's nursing notes showed the resident had been readmitted to the facility from the hospital on 1/13/14. The resident's diagnoses included severe sepsis, influenza-A and acute renal failure. On 3/10/14 the nursing notes showed, "try pureed foods."	F 325		

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F 325	<p>Continued From page 30</p> <p>There was not a nutritional assessment provided to show timely assessment and implementation of nutritional interventions in an attempt to prevent this resident's significant weight loss after being hospitalized with severe infection and renal failure.</p> <p>c. Review of the MDS assessments included: 2/8/14 (quarterly MDS) identified weight loss 5% and weight of 140 pounds, 5/9/14 (annual MDS) identified weight loss 5 % and weight of 137 pounds.</p> <p>d. Review of the dietary assessment dated 6/14/14 by the RD included the following entries:</p> <p>- " Significant wt. Change (loss), Diet order NAS (no added salt) pureed/soft foods, 4 oz Ensure with meals, usually consumes 50 to 100% of meals, additional supplement - 4 oz. Ensure with meals 50 to 100%, ...percent of weight change in last 180 days (minus) 14%, "</p> <p>- "Has had sores to month/lips which have inhibited ability to wear dentures. That's why the pureed/soft foods were started. Spouse requests that textures are continued even after sores heal as resident is accepting them."</p> <p>- "Current weight 136 lbs. Inadequate energy intake related to dementia, health status evidenced by wt. loss, BMI (Body mass index) - 18.4."</p> <p>- " Summary: Interventions were implemented last month and a modest gain has occurred. Now offering the Ensure more consistently and it seems to be okay. Will cont. current plan and monitor." [Interview with the CDM on 6/18/14</p>	F 325		

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F 325	<p>Continued From page 31</p> <p>confirmed there had been issues of ensuring supplements were consistently offered and documented.]</p> <p>e. Review of the resident's "Plan of Care" identified the resident's problem of "impaired nutritional status". The goal dated 5/12/14 listed to maintain adequate nutrition with in 5 lbs. of current wt. 130 lbs. or goal to gain 1-2 lbs. per quarter. Additionally, the resident will be offered extra high calorie foods. The interventions listed:</p> <p>- 5/12 14: small eater and prefers the small servings with snacks offered, fresh fruits at brk. (breakfast) likes coffee and water 3 x, prefers no milk at meals likes cereal or soup at supper on occ. Nutritional supplement 4 oz. Ensure at AM snack, mighty shake at PM and magic cup at HS."</p> <p>-The interventions also showed that the on 8/2013 "all supplements dc'd due to significant wt. gain and per family's request."</p> <p>[Note: The weight record for 8/2013 showed the resident weight at that time was 159 pounds. The weight on survey 6/17/14 was 134.5 lbs, a 24.5 lbs weight loss in 10 months. However the goal states maintain a weight of 130 lbs. It was not clear why goal of 130 pounds was identified for this resident who is 71.75 inches (5 foot 11 3/4 inches) tall. There was no evidence that the resident's disease processes and illnesses were assessed and calculated into the nutritional recommendations.]</p> <p>f. Review of the resident's dietary sheet which</p>	F 325			

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F 325	Continued From page 32 the CDM (D) confirmed it was the form used by the dietary staff when serving the resident's meal revealed : Diet: NAS (no added salt), Consistency - pureed -soft, Beverages to include: Breakfast - Ensure 4 oz; Dinner (noon meal) - Ensure 4 oz; Supper (evening meal) - Ensure 4 oz. Snacks: NONE LISTED There was no indication that staff were offering extra high calorie foods, or mighty shake at PM and magic cup at HS was listed on this resident's the diet form. g. Interview with CDM (D) on 6/18/14 revealed that residents' meals can be fortified with extra calories (such as cereal with added brown sugar, milk powder, or butter, extra gravy, extra butter, etc.). However, there was no evidence that these high calorie foods were being given to this resident.	F 325			
F 428 SS=F	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	It is recognized that pharmacy recommendations must be reported to the physician and director of nursing and physician and the reports must be acted upon. It is acknowledged that the facility policy initiated by the medical staff, to wait until the next resident certification to address pharmacist recommendations did not ensure the pharmacists monthly drug review were acted on in a timely manner. In addition it is recognized that the pharmacy recommendations for resident #4 were not addressed in a timely manner nor was documentation in compliance with regulation.	07/29/14	

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F 428	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy and procedures, and staff interview the facility failed to have a system to ensure the pharmacist completed a thorough evaluation of residents' medication regimen for irregularities and that those irregularities were reported to the attending physician and the director of nursing, and these reports were acted upon. An example was identified for one of 12 sampled residents (#4). The findings included: PROCESS FAILURE: 1. Interview with the DON (Director of Nursing) on 6/18/14 confirmed the consultant pharmacist was completing a medication regimen review for each resident monthly. The findings from the monthly reviews were documented in each resident's record. However, the attending physicians did not act upon those recommendations or identified irregularities unless it coincided with the 60 day recertification visit. The DON reported that was the policy decision made through the hospital committee. The pharmacist reports showing irregularities did not show they were reviewed by the attending physician and the DON, and these reports were acted upon timely. 2. Review of the facility's Policy and Procedure for "Consultant Pharmacist Services Provider Requirements" was dated 12/2012 and included:	F 428	Beginning July 7, 2014, upon receiving pharmacy recommendations DON will fax pharmacy reports to providers. Provider will assess if recommendation requires immediate intervention or if they feel it is appropriate to wait until resident's next recertification to address. Provider will fax back to Platte Care Center and a copy of the fax will be retained in the resident's chart. Orders will be noted and entered into EMR. Consultant pharmacist policy was updated to reflect this change on 7/2/14. Physicians were educated on policy change by CEO on 7/7/14. By 7/29/14 CEO will review F 428 deficiency and provide education on plan of correction with each physician who is a primary care provider for residents at the Platte Care Center. Upon completion of education primary physician for resident #4 will review resident #4 medical record including recent pharmacy reviews, and current psychotropic medications. Provider will update medical plan of care as appropriate and document in progress notes according to F428 guidelines. This will be completed by July 25, 2014. On July 15 and 16, 2014, nurses and CNA's received education on F428 deficiency and plan of correction. Physicians were educated when answering pharmacy recommendations and or changing psychotropic medications the provider needs to document why the dose is being changed. Documentation must include what behavior is requiring the medication change, risk versus benefit for utilizing medication taking into consideration side effects in elderly, black box warnings, documentation of why multiple medications are being used and if there are concerns with drug to drug interaction. (Falls are a concern with most of these medications so may need to be addressed if resident having frequent falls and remaining on psychotropic). When starting a new psychotropic medication the progress note must indicate what other interventions including pain management that have been tried prior to utilizing psychotropic. Physicians also educated that when ordering a new psychotropic medication the order must contain an accompanying diagnosis and target behavior.	07/29/14

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F 428	<p>Continued From page 34</p> <p>"Policy: The Consultant Pharmacist provides regular and reliable services to residents. A written agreement with a Consultant Pharmacist describes financial arrangements and the terms of the services provided.</p> <p>Procedure: The Consultant Pharmacist agrees to provide the required service in accordance with local, state and federal laws, regulations, and facility guidelines; policies and procedures; and community standards of practice. The facility agrees to notify the Consultant Pharmacist each time a new resident is admitted to the facility.</p> <p>-3. The Consultant Pharmacist provides Consultant Pharmacist services, including but limited to the following; ...</p> <p>d. Reviewing the medication regimen of each resident at least monthly, utilizing federally mandated standards of care in addition to other applicable standards and documenting the review and findings in the resident's medical record.</p> <p>e. Communicating potential problems relating to medication therapy orders to the responsible physician.</p> <p>f. Assuring proper documentation of medication orders by reviewing medication administration records and physician orders.</p> <p>g. Assuring proper administration of medication to residents by reviewing EMARs and physician orders.</p> <p>h. Submitting a written report of findings and recommendations resulting from the medication regimen review and nursing documentation</p>	F 428	<p>On July 16, 2014 a Nurse and SSD reviewed all residents' records, behaviors and psychotropics. A targeted behavior was selected based on RN, CNA and physician documentation for every psychotropic a resident is receiving. Upon completion of training with CEO, Clinic nurse manager will provide each provider faxes on each resident, containing their psychotropic medications and proposed targeted behavior for each psychotropic. Residents' primary provider to review the list of targeted behaviors and medications and sign fax to approve or make changes where appropriate. Nurses will retain fax in resident's medical record. Once fax is received nursing will enter targeted behavior in EMAR. Targeted behaviors will be visible in EMR and with medications on physician recertification sheet. This will be completed by August 2, 2014.</p> <p>Monthly beginning August 2014, DON or selected nurse will monitor all residents on psychotropic's monthly for side effects. This will be documented in the Psychological medication intervention. AIMS scale will be completed on every resident who is on an antipsychotic monthly. CNA's will continue to document on behaviors and non pharmacologic interventions. Nurses will complete the change of medication charting and will list diagnosis, targeted behavior, current behaviors and pharmacological and non pharmacological interventions and effectiveness when charting. This will be completed twice daily every week for four weeks when each new or change in psychotropic medication occurs. A sample of documentation was provided to all Nurses.</p> <p>SSD will continue to complete monthly depression evaluation on all residents psychotropic medication. SSD also reviews CNA documentation of all mood and behaviors on residents with psychoactive medication and assesses if number has increased or declined in the previous month.</p> <p>In an effort to ensure complete and timely attention to pharmacy recommendations, starting August 2014 DON will complete monthly psychotropic medication audit on 25% of residents who had a pharmacy review in the previous month. Audit will include review of the physician progress notes and nurse, CNA and SSD documentation on psychotropic medications.</p>	08/02/14

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F 428	<p>Continued From page 35</p> <p>records to the Director of Nursing and Administrator. The attending physician will be notified of resident needs either by the Pharmacist or by the Director of Nursing. Recommendations for medication changes will be taken by the DON to the clinic. Routine Lab recommendations will be placed on the chart and reviewed by the physician with the next scheduled recertification for the resident...."</p> <p>This policy and procedure did not ensure the pharmacist's monthly drug reviews were acted upon timely.</p> <p>RESIDENT ISSUES:</p> <p>1. Resident #4's medical record review revealed the resident was admitted to the facility on 6/11/12 with diagnoses which included: CHF (congestive heart failure), HTN (hypertension), renal failure, dementia and history of left leg fracture.</p> <p>a. Review of the resident's current MDS (Minimum Data Set) assessment dated 12/11/13 identified the resident as having cognitive impairment with a BIMS (Brief Interview for Mental Status) score of 5 (0-7 indicates severe cognitive impairment). It also showed the resident as having falls and wandering.</p> <p>b. Review of resident #4's June 2014 "Physician Order Sheet" revealed the resident's current medications included:</p> <p>-Buspar 10 mg for anxiety started 6/12/14, [Note: Buspar is used to treat anxiety disorders or in the short-term treatment of symptoms of anxiety.]</p>	F 428	<p>DON will report compliance on the care center dashboard monthly beginning August, 2014 and report to the Platte Health Center Quality Team monthly beginning in October 2014.</p>	08/02/14

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F 428	Continued From page 36 -Remeron 30 mg at bedtime for depressive disorder started 2/24/14 (increased from 30 mg), [Note: Remeron is an antidepressant. This medication has Black Box Warning-"Use cautiously in patients with CV or cerebrovascular disease, seizure disorders, suicidal thoughts, hepatic renal disease or history of mania or hypomania... Also give cautiously to elder patients; decreased clearance has occurred in this age group. Also risk of drug to drug interactions with other CNS depressants."] -Aricept 10 mg started 1/26/14, [This medication is use is in the treatment of Alzheimer's disease.] -Seroquel 12.5 mg indicator agitation, disturbances/ angry with staff and wife, dementia started 1/26/14. Also noted PRN (as needed) dose for Seroquel dated 2/25/14, [Note: Seroquel is an atypical antipsychotic medication, which comes with a BLACK BOX WARNING for increased risk of death in elderly patients. It is not approved for use in patients with dementia-related psychosis.] There was no indication for use or documentation of risk benefit with the use of this medication. There was also no documentation provided during the survey to show what specific / targeted behaviors were being monitored for use of this medication. There was no indication that the resident was being monitored for use of multiple medications with same affect and potential for drug to drug interaction. The example is multiple medications with potential for anticholinergic side affects.	F 428		

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F 428	<p>Continued From page 37</p> <p>-Lasix 80 mg for hypertension started 1/26/13, (Diuretic)</p> <p>c. The monthly Consultant Pharmacist drug regimen reports were reviewed from 9/11/13 to 6/4/14 for resident #4 which included:</p> <p>-11/7/13 "Patients medications, dictations and labs reviewed. No significant findings, and no recommendations at this time. Awaiting patient to be seen in Nov. for recert to see if can d/c PRN Seroquel. Staff had interesting intervention with patient's behavior, were able to calm him down by just drawing up Haldol, patient hates needles so he went to room and settled down and staff was able to avoid giving medication."</p> <p>-12/6/13 "Reviewed patients medications, labs and office visits. Patient due for trial dosage reduction for his mirtazapine 15 mg. Please review and document decision. Thanks..."</p> <p>-1/13/14 "Patient's medications, labs and office visits were reviewed. Did not see a response to last months's request for trial dosage reduction with Mitazapine (Remeron). I will add another to it as (resident name__) is now due for trial dosage reduction with Seroquel 12.5 mg Bid. Please evaluate both meds/ the benefits vs. risks and document decision. Also note that his PRN Seroquel dose had been discontinued, however it is still on med list. Please clarify. Thanks."</p> <p>[Note: Both medications have BLACK BOX WARNING and there was not timely follow up or explanation as to why or how the benefit of this medication with potential for clinically significant adverse consequences outweighs the risk.</p>	F 428			

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F 428	<p>Continued From page 38</p> <p>Additionally, there was no evidence that there was a specific targeted behavior being tracked and monitored with the use of an antipsychotic medication.]</p> <p>-2/5/14 "Patient's medications, labs, notes and Dr. dictations were reviewed. There were no findings or recommendations at this time. Note that previous dose reduction request were denied- Dr. did express interest in decreasing Seroquel in future."</p> <p>However there was no documentation provided at the time of survey for the follow up by the physician with explanation as to why or how the benefit of this medication with potential for clinically significant adverse consequences outweighs the risk for this resident. Additionally no documentation of monitoring or tracking specific behavior or diagnose for use.</p> <p>-3/7/14 "Patient's medications, labs, notes and Doctor's dictations were reviewed. Nothing significant found or recommendations at this time. Noted some med changes, PRN Seroquel was added again and Mitazapine (Remeron) is now 30 mg (increased)."</p> <p>-4/7/14 to 6/4/14 No recommendations identified.</p> <p>The pharmacist drug reviews failed to identify that the resident's drug regimen was free of any drugs irregularities which included; medications with BLACK BOX warnings, duplication of drugs (drugs having same effect), and drugs without adequate indications for its use without adequate monitoring or potential for dangerous adverse reactions. There was no evidence the pharmacist was identifying the residents at risk for</p>	F 428		

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F 428	Continued From page 39 anticholinergic side effects. REFERENCE: THE AMERICAN GERIATRICS SOCIETY 2012 "This clinical tool, based on The AGS 2012 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (AGS 2012 Beers Criteria), has been developed to assist healthcare providers in improving medication safety in older adults. Our purpose is to inform clinical decision-making concerning the prescribing of medications for older adults in order to improve safety and quality of care. The goal of this clinical tool is to improve care of older adults by reducing their exposure to Potentially Inappropriate medications (PIMs). This should be viewed as a guide for identifying medications for which the risks of use in older adults outweigh the benefits..."	F 428		
F 441 SS=F	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.	F 441	It is recognized that on 6/18/14 during the environmental survey, that our soiled utility room in laundry did not have negative air pressure flow as required by law. POC On 7/8/14 work was completed by Paulson Sheet Metal to correct our problem in soiled utility. It was corrected by adding 2 new exhausts in the one wall, in addition to the one already there. There are now 3 exhaust each exhausting 210 CFMs for the 630 CFM to the outdoors. The vent between soiled utility and clean room now draws 460 CFMs out of clean room thru soiled utility making soiled utility room negative air. Maintenance staff was instructed on 7/14/14 to monitor air flow weekly beginning 7/14/14 and to log the same. Maintenance supervisor will be responsible to check logs beginning on 7/14/14 and report to QA. The air flow logs will be reported to QA quarterly beginning on 7/14/14.	07/14/14

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F 441	<p>Continued From page 40</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to ensure that the laundry was processed in a manner to minimize the potential for the spread of infection. Specifically, the air flowed from the dirty side to clean side of the laundry area. The findings included:</p> <p>1. General observations during the environmental tour on 6/18/14 from 3:00 PM to 3:45 PM with the Maintenance Director revealed the following:</p> <p>a. The laundry room processing the hospital and nursing home linens was located in the hospital side of the facility. The laundry room consisted of</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER PLATTE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 609 EAST 7TH POST OFFICE BOX 200 PLATTE, SD 57369	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 41</p> <p>two rooms. The Maintenance Director reported the smaller room laundry room was used for sorting and handling soiled linens. The adjacent larger laundry room had washing machines, dryers, and an area for processing clean linens.</p> <p>Observation of the small laundry room identified as the soiled or dirty side of the laundry had laundry bins with bags of linen noted in the bins and on the floor next to the bin. There was an opening (vent) at ceiling level in the wall going into the larger (clean) side of the laundry. The Maintenance Director reported it was the ventilation or duct work for the laundry. He then asked another maintenance staff to get a ladder to check the air flow. The staff held a paper towel up to the vent. The paper towel was drawn to the clean side of laundry.</p> <p>The Maintenance Director reported that the airflow was going the wrong direction. He confirmed the current airflow did not have the required negative airflow to prevent cross contamination of the clean linen. He then asked the other maintenance staff to check the three vents on the opposite wall. When checked one had airflow into the room and two pulling air out of the room. He then reported he would follow up with the engineers.</p> <p>2. Interview with the Administrator on 6/19/14 at 3:15 PM revealed that the blueprints for the laundry room had been pulled and the engineers had been called. The temporary fix to the airflow problem in the laundry room was the closure of the vent between the two laundry rooms and the closure of two of the three vents on outside wall. The Administrator reported that the blueprints did not match the actual construction and they would</p>	F 441		

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

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F 441	Continued From page 42 address the problem. The facility failed to ensure that the laundry was processed in a manner to minimize the potential for the spread of infection. Reference: Guidelines for and Construction of Health Care Facilities: Ventilation Requirements- Soiled linen sorting and storage, Negative pressure relationship to adjacent areas and exhausted directly to the outside. "Design of the ventilation system shall provide air movement which is generally from clean to less clean areas..."	F 441			