

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

ORIGINAL

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/11/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105</b>	
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F 000	INITIAL COMMENTS  Surveyor: 22452 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/2/14 through 9/11/14. Southridge Health Care Center was found not in compliance with the following requirements: F157, F164, F166, F204, F221, F222, F224, F225, F226, F241, F248, F252, F278, F279, F280, F281, F309, F314, F322, F323, F325, F327, F332, F333, F353, F356, F368, F371, F385, F425, F428, F431, F441, F490, F493, F505, F514, and F520.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as	F 157	1. Resident 7's record was reviewed. The physician was notified by the facility. The resident was determined not to have any negative outcomes related to lack of notification. The clinical records for all residents who had an accident resulting in an injury requiring physician notification, a significant change in status, and/or a significant alteration in treatment in the last 60 days were reviewed for physician notification. 2. A facility policy and procedure has been developed for notification of the physician, resident and/or responsible party related to change of condition.	10/10/14

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

TITLE

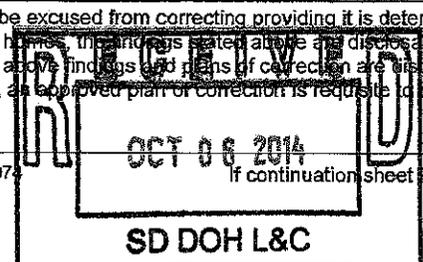
(X6) DATE

*[Signature]*

*Administrator*

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 and 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 157	<p>Continued From page 1</p> <p>specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review and interview, the provider failed to notify primary physician I of a suprapubic catheter (a tube inserted into the bladder through a small hole in the belly that drains urine) placement done at the Veteran's Administration (VA) hospital for one of three residents (7) with a suprapubic catheter (catheter inserted directly into the bladder). Findings include:</p> <p>1. Review of resident 7's medical record revealed: *A form from the surgical center indicated the suprapubic catheter placement surgery had been scheduled for 8/27/14. *An interdisciplinary note dated 8/27/14 indicated "OOF [out of facility] with daughter to VA for S/P [suprapubic] placement." *A patient instruction sheet for wound/incision care was not signed and not dated. *There was no documentation staff had notified primary care physician I of the suprapubic placement.</p> <p>Interview on 9/9/14 at 11:15 a.m. with primary physician I regarding resident 7 revealed:</p>	F 157	<p>A daily (M-F) clinical stand-up meeting with the interdisciplinary team (IDT) was started on 9/30/14 to communicate changes of condition and other significant clinical situations. Physician notification of condition changes are discussed as part of the IDT clinical meeting. The Director of Nursing will prepare for the daily clinical stand-up by reviewing the communication at each unit. The MDS Case Managers will prepare by reviewing the documentation for the changes of condition and other significant clinical situations to ensure appropriate documentation, including physician and resident/responsible party notification, has occurred with appropriate follow-up. The MDS Case Managers will report to the Director of Nursing if documentation was lacking.</p> <p>3. At monthly QAPI meetings, the DON will report on the frequency of the lack of physician and resident/responsible party</p>	

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F 157	Continued From page 2 *He had not been informed of the suprapubic catheter placement done on 8/27/14. *He had just learned of the suprapubic catheter at the time of the interview with surveyor. *The resident was a VA patient, but he was still his primary care physician. *The staff never tell him what was going on with the residents under his care. *They did not a policy on physician notification.  Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, pp. 357 and 358, revealed: *Nurses should communicate information about patients (residents) to help team members make appropriate decisions about patient care. *A nurse makes a telephone report when significant events or changes in a patient's condition have occurred.	F 157	notification and decisions will be determined for further performance improvement action based on the result of those audits. These reports will occur until the QAPI committee determines otherwise.	
F 164 SS=C	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164	1. The wooden holder on the MDS office door was removed on 9/29/14. 2. The Family Flu Vaccine Consent forms are now kept at the nurses' stations in a folder. 3. During daily rounds, seven days a week, the DON or designee will verify that no confidential resident information is accessible or visible to the public. If any issues are identified, the DON will provide a report at the monthly QAPI	10/10/14

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F 164	<p>Continued From page 3</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, and policy review, the provider failed to maintain confidentiality of residents' medical records for flu vaccination consents)for all residents requiring flu vaccinations. Findings include:</p> <p>1. Observation on 9/2/14 at 5:45 p.m. of an unmarked door on the east hall next to resident rooms 303 and 304 and across the hall from the tub room revealed: *A wooden holder affixed to the center of the door. *In the above holder there were papers in a file marked Family Flu Vaccine Consent Form that contained the following residents' information on the fax cover sheets for each resident: -Name of the resident. -Admission date. -Date of birth. -Physician's name. *The holder that contained the above information had been accessible to a resident in a wheelchair and any other residents or visitors.</p>	F 164	meeting for determination of a performance improvement action.	

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F 164	Continued From page 4 Surveyor: 32331 Observation on 9/9/14 at 4:55 p.m. of the same unmarked door identified the above findings was unchanged and revealed: *One unidentified resident walked by. *Two unidentified residents were seated in wheelchairs.  Interview on 9/9/14 at 4:56 p.m. with the administrator and the nursing home consultant at the above location regarding the papers in a file marked Family Flu Vaccine Consent Form revealed: *They agreed the location was accessible to residents and visitors. *They confirmed the papers contained confidential resident information. *They agreed the location of the papers was not appropriate. *The administrator immediately removed the papers from that location.  Review of the provider's April 2011 Confidentiality of Resident Information policy revealed: *Resident information was to have been treated as confidential. *Access to a resident's personal information was to have been limited to the staff and consultants providing care/services to the resident.	F 164			
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES  A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	F 166	1.The Grievance/Event Report form was revised to include which member of the IDT is assigned to investigate the concern, complete follow-up resolution, and notify the	10/10/14	

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F 166	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335</p> <p>Based on interview, resident council minutes review, grievance report reviews, employee NN's file review, and policy review, the provider failed to resolve three of three resident grievances regarding:</p> <ul style="list-style-type: none"> <li>*Certified nursing assistant (CNA) NN.</li> <li>*Residents disturbing other residents.</li> <li>*Getting requested items from the dietary department.</li> </ul> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Group interview on 9/3/14 at 11:00 a.m. revealed: <ul style="list-style-type: none"> <li>*Ten residents attended the group meeting.</li> <li>*Four anonymous residents stated they had reported CNA NN to the prior director of nursing (DON), because of her negative attitude and negative behavior towards them that included yelling at residents and not helping them when they needed help.</li> <li>*They could not remember the dates of when they had reported CNA NN to the DON.</li> <li>*The prior DON was no longer employed at the facility.</li> <li>*CNA NN had remained employed at the facility but had turned in her two weeks notice. She would be done with her employment soon.</li> <li>*The residents who had filed the grievances had not heard anything back from the administration.</li> <li>*The group felt when they took concerns to the administration nothing got done.</li> <li>*The administrator would say "I am working on it," but would never get back to the residents.</li> </ul> </li> </ol> <p>Review of the 7/10/14 resident council minutes</p>	F 166	<p>concerned person(s) to confirm satisfactory resolution; and to include signature of the Administrator and Director of Nursing to verify that the investigation was thorough, the follow-up resolution was completed, and the concerned person(s) was satisfactorily notified of resolution.</p> <p>2. The Social Services Coordinator or designee was designated to coordinate the grievance process. Grievances received the previous day will be reviewed during the daily (M-F) stand-up meeting, and appropriate department manager assigned to investigate, follow-up, and notification of resolution within five days. The grievance form and policy were revised to link the grievance process to the Resident Council concerns and to the abuse investigation process if investigation of the concern indicates potential for abuse,</p>	

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F 166	<p>Continued From page 6</p> <p>revealed residents had voiced concerns regarding:</p> <ul style="list-style-type: none"> <li>*Other residents constantly hollering.</li> <li>*Dietary staff telling them they are out of requested items.</li> </ul> <p>Review of the 8/4/14 resident council minutes revealed:</p> <ul style="list-style-type: none"> <li>*Under new business the following issues were listed: <ul style="list-style-type: none"> <li>- "Residents are concerned with the disruptive yelling of other residents."</li> <li>- "Residents are tired of going to the kitchen asking for things and being told they are out."</li> </ul> </li> <li>*Those had been the same concerns identified by residents at the July meeting.</li> </ul> <p>Review of the grievance reports from June 2014 through 9/2/14 revealed no documentation of the grievances made by the residents regarding:</p> <ul style="list-style-type: none"> <li>*CNA NN.</li> <li>*Residents hollering and yelling.</li> <li>*Dietary staff telling them they are out of requested items.</li> </ul> <p>Review of CNA NN's employee file revealed no investigation or disciplinary action regarding the concerns brought up by the residents.</p> <p>Interview on 9/9/14 at 2:35 p.m. with the administrator and the DON revealed:</p> <ul style="list-style-type: none"> <li>*The current DON had been employed since 8/14/14 and was unaware of the grievances made by the residents regarding CNA NN.</li> <li>*Any disciplinary action taken against an employee would have been in the employee's file.</li> <li>*The administrator had been aware of the grievances made by the residents regarding CNA NN.</li> </ul>	F 166	<p>neglect, mistreatment, or misappropriation of resident property. All staff were educated on the process for reporting and completing the Grievance/Event Report form. The IDT were educated regarding the process for investigation, follow-up, and notification of resolution.</p> <p>3. The SSC will audit all grievances for the previous month for timeliness, completeness and accuracy, and will provide a report to the monthly QAPI committee. These audits will be ongoing or until the QAPI committee determines otherwise.</p>	

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F 166	Continued From page 7 *There had been no investigation conducted on the residents' grievances. *He had no explanation as to why the grievances had not been followed up on.  Review of the provider's 11/8/12 grievance/complaints policy revealed: **Complaints or grievances may be able to be resolved within the facility. *Any resident admitted or treated, or seeking admission or treatment is privileged to use this grievance mechanism and may initiate any oral or written complaint. *Any complainant has the right to request and to receive a written response to any complaint within a reasonable period of time. *You may voice grievances and recommend changes free from restraint, interference, coercion, discrimination, or reprisal, including the threat of discharge."	F 166		
F 204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG  A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.  In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r).  This REQUIREMENT is not met as evidenced	F 204	1. Resident 31 was contacted. The resident was determined not to have any negative outcomes related to the lack of discharge instructions related to the skin care orders. All residents who discharge from the facility could be at risk for negative outcomes if not properly educated at the time of discharge. 2. The Discharge Instructions form was revised to include more information related to medications	10/10/14

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F 204	<p>Continued From page 8</p> <p>by: Surveyor: 32332</p> <p>Based on record review and interview, the provider failed to ensure discharge instructions included education on skin care for one of one sampled resident (31) who had skin breakdown upon discharge. Findings include:</p> <p>1. Review of resident 31's medical record revealed: *A 8/19/14 physician's order for DuoDerm (a skin dressing) to have covered a red area at the top of his coccyx (tailbone). *A 9/2/14 physician's order to discharge to home with the same medications and treatments. *A 9/2/14 Discharge Instructions form with Summary of Condition on Discharge signed by the resident's wife and the nurse that discharged the resident. *The Discharge Instructions form had not included any skin care concerns or directions for use of the DuoDerm. *There was no documentation that reflected his skin concerns had been resolved at the time of his discharge.</p> <p>Interview on 9/10/14 at 10:40 a.m. with the director of nursing revealed the Minimum Data Set (MDS) nurse would have been responsible for the education provided at discharge.</p> <p>Interview on 9/10/14 at 12:20 p.m. with the MDS Coordinator QQ revealed: *She had not participated in discharging the residents. *The nurse who was working the Warren unit at the time of discharge was responsible for discharge education to the residents and family. *Her expectation was the resident and family</p>	F 204	<p>and treatments. The IDT was educated regarding the revised form and the discharge education process.</p> <p>3. At monthly QAPI meetings, the Director of Nursing or Medical Records Coordinator will report on a 100% audit of the Discharge Instructions form against the closed clinical record to verify accuracy of the discharge instructions. These audits will occur weekly for 90 days, and then bimonthly for 90 days, until the QAPI committee determines otherwise. When the discharge education process is determined to be in place, the audits will be discontinued.</p>		

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F 204	Continued From page 9 should have been educated on skin concerns at the time of discharge. *They did not have a policy regarding residents' discharge instructions.  Review of Patrician A. Potter and Ann Griffin Perry, Fundamentals of Nursing, 6th Edition, Mosby, St. Louis, Mo, 2005, revealed, page 492: *When a patient was discharged from inpatient care a discharge summary was prepared by various members of the healthcare team. *Discharge forms: -Made the summary concise and instructive. -Emphasized previous learning by the client and family, and what care should be continued.	F 204			
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS  The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.  This REQUIREMENT is not met as evidenced by: Surveyor: 32331 A. Based on observation, record review, interview, and policy review, the provider failed to accurately assess: *One of one resident (14) who used a seat belt in his wheelchair (w/c) for positioning and was unable to release the seat belt independently. *One of one resident (16) whose care plan indicated staff were to unplug the remote control to his recliner when he was in it. Findings include:	F 221	1. The chair or bed equipment for Residents 10, 14, and 16 were assessed for appropriateness related to their medical symptoms using the Physical Restraint Assessment form and the clinical records were reviewed. The residents were determined not to have any negative outcomes related to the use of the chair or bed equipment. The clinical records for all residents who use equipment on their chair and/or bed were reviewed to ensure the equipment was properly assessed for appropriateness related to	10/10/14	

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F 221	<p>Continued From page 10</p> <p>1. Review of resident 14's medical record revealed: *He had been admitted on 7/3/14. *There was no physician's order for the use of the seat belt. *There was no assessment to indicate the use of the seat belt.</p> <p>Review of resident 14's 7/15/14 Interdisciplinary Progress Notes revealed: *Minimum Data Set (MDS) coordinator E had documented: -He had his own w/c with a seat belt. -He was unable to release the seat belt. -That seat belt was considered a restraint.</p> <p>Review of resident 14's 7/17/14 Occupational Therapy (OT) Plan of Care revealed: *He was at risk for falling out of his w/c. *He was unable to use his seat belt independently. *He had been using a seat belt to keep him positioned appropriately. *He had not been allowed to use the seat belt as he could not manage it himself. *Therapy was to have come up with an alternate method to keep him safely positioned in his w/c.</p> <p>Review of resident 14's admission MDS assessment on 7/10/14 revealed: *Restraints were coded zero (none) for all areas in section P under physical restraints. *Those areas used in the chair or out of the bed had included: -Trunk restraint. -Limb restraint. -Chair prevents rising. -Other.</p>	F 221	<p>to the medical symptoms.</p> <p>2. All side rails will be removed and replaced with transfer rails upon receipt of them as soon as received; order was placed on 10/3/14. A Physical Restraint Assessment form was developed to ensure a systematic assessment of the chair or bed equipment is completed to include the resident's medical symptom(s), cognitive and physical function, observation of the resident to determine the effect the equipment has on the resident's function, whether the resident can easily and voluntarily remove the equipment, and a determination of whether the equipment meets the definition of a physical restraint. The Restorative Nurse was designated to coordinate the assessment of chair and bed equipment with input from the therapy department. The Restorative Nurse will report on residents who have a new or revised need for chair or bed</p>		

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F 221	<p>Continued From page 11</p> <p>Interview on 9/8/14 at 1:45 p.m. with OT T regarding resident 14 revealed: *On 7/17/14 he had a seat belt. *He had been unable to independently release the seat belt when it was buckled. *That would have been a restraint as he was unable to independently release the seat belt. *She had recommended on her evaluation form to use the tilt mechanism in his w/c to allow improved positioning. *She was unsure when the seat belt buckle had been discontinued. *There had been no assessment completed for the use of the seat belt.</p> <p>Interview on 9/9/14 at 9:10 a.m. with MDS coordinator E regarding resident 14's seat belt use revealed: *The seat belt had been considered a restraint. *That seat belt had been on him during the initial MDS assessment period. *It should have been coded on the 7/10/14 admission MDS assessment under: -Trunk restraint. -Chair prevents rising. *He would have been unable to release the seat belt when it was buckled. *She agreed the provider had not accurately assessed him for the seat belt.</p> <p>Interview on 9/10/14 at 8:15 a.m. with the director of nursing regarding resident 14's seat belt use revealed she confirmed: *There had been no assessment completed for the seat belt. *There was no physician's order for the use of the seat belt.</p> <p>Observation on 9/10/14 at 9:45 a.m. of resident</p>	F 221	<p>equipment during the daily (M-F) clinical stand-up meeting with the interdisciplinary team (IDT). The IDT was educated regarding the revised form and the physical restraint assessment process.</p> <p>3. At monthly QAPI meetings, the Director of Nursing or designee will report on the IDT clinical stand-up review of all residents with physical restraint assessments to verify accuracy and appropriateness of the equipment used, and decisions will be determined for further performance improvement action based on the result of the report. The reports on physical restraint assessment process will occur until the QAPI committee determines otherwise.</p>		

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F 221	<p>Continued From page 12</p> <p>14's w/c revealed an unbuckled seat belt attached to both sides of the inside of the w/c. Surveyor: 32335</p> <p>2. Review of resident 16's 6/12/14 care plan revealed:</p> <ul style="list-style-type: none"> <li>*A problem area related to falls and the use of psychotropic medication (any medication capable of affecting the mind, emotions, and behavior).</li> <li>*An undated intervention that stated "Remote to recliner to be unplugged while resident in chair so unable to adjust the height."</li> <li>*On 6/20/14 he fell in the dining room.</li> <li>*On 6/24/14 he fell in his room.</li> <li>*On 6/24/14 he was diagnosed with a urinary tract infection and started on antibiotics.</li> <li>*On 6/25/14 he fell from the recliner in his room.</li> <li>*On 7/3/14 he was found next to his recliner.</li> <li>*On 7/29/14 he fell out of his wheelchair in a doorway.</li> </ul> <p>Review of resident 16's 8/20/14 Minimum Data Set (MDS) assessment revealed:</p> <ul style="list-style-type: none"> <li>*He had an admission date of 5/30/14.</li> <li>*His cognition (thinking) level was severely impaired.</li> <li>*He needed extensive physical assistance from two staff members for transfers.</li> </ul> <p>Interview on 9/10/14 at 9:15 a.m. with certified nursing assistant (CNA) C regarding resident 16 revealed she had:</p> <ul style="list-style-type: none"> <li>*Worked with him on her shift that day.</li> <li>*Not seen his care plan and was unsure of what it said regarding the recliner.</li> <li>*Not been trained on what to do when using his recliner.</li> <li>*Put him in the recliner and reclined him back with his feet up.</li> <li>*Not unplugged the recliner, but she had put the</li> </ul>	F 221			

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F 221	<p>Continued From page 13 remote in the pocket out of his reach.</p> <p>Observation on 9/10/14 at 9:20 a.m. in resident 16's room revealed the recliner was unplugged.</p> <p>Interview on 9/10/14 at 9:25 a.m. with CNA LL regarding resident 16 revealed: *She had unplugged the recliner when she assisted him into it. *She would not put his feet up when she unplugged the recliner. *She was unaware of what the care plan stated regarding unplugging the chair. *She had started unplugging the recliner, because he had several falls recently.</p> <p>Interview on 9/10/14 at 9:50 a.m. with MDS coordinator E regarding resident 16 revealed: *She had added the intervention of unplugging his recliner, because he had slid out of his recliner once when he attempted to run the controller. *She had not assessed his ability to operate the chair to determine if unplugging the recliner would be a restraint. *She had not indicated on the care plan to keep his feet down and not recline the chair when the recliner was unplugged. *She knew it would have been considered a restraint if he was in the chair with his feet up, and the recliner was unplugged.</p> <p>3. Review of the provider's 6/11/14 Use of Restraints policy revealed: **Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. *Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the</p>	F 221		

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F 221	Continued From page 14 prevention of falls. *The definition of a restraint is based on the functional status of the resident and not the device. *If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition, and this restricts his/her typical ability to change position or place, that device is considered a restraint. *Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: -Placing a resident in a chair that prevents the resident from rising. *Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention and a restraint is required to: -Treat the medical symptom. -Protect the resident's safety. -Help the resident attain the highest level of his/her physical or psychological well-being. *Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. *The assessment shall be used to determine possible underlying causes of the problematic medial symptoms and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. *Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. Surveyor: 32332 B. Based on observation, record review, interview, and policy review, the provider failed to follow their Comprehensive Mobility Assessment recommendations for the use of side rails/transfer bars for one of two sampled residents (10) who	F 221			

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F 221	<p>Continued From page 15 used side rails. Findings include:</p> <p>1. Random observations from 9/2/14 through 9/10/14 of resident 10's bed revealed two half side rails (transfer bars) attached to each side at the head of the bed.</p> <p>Review of resident 10's medical record revealed: *A 6/10/14 Comprehensive Mobility Assessment indicated: -She used one transfer bar (side rail) on her right side in bed to turn in bed. -She used a body pillow for her left side in bed. -There was a physician's order for the use of the transfer bar (side rail). -There was a signed consent by her power of attorney for the use of the transfer bar (side rail). -Use of the transfer bar (side rail) had been added to the care plan. *The 7/17/14 care plan indicated she had bilateral (on both sides of the bed) transfer bars to aid with bed mobility.</p> <p>Interview on 9/10/14 at 10:00 a.m. with MDS coordinator J revealed: *She had completed the side rail/transfer bar assessment on 6/10/14. *That assessment was called the Comprehensive Mobility Assessment. *It was to have been used to write the care plan. *She had been aware the assessment had not matched information on the care plan. *She would have used the care plan information to care for the resident rather than the assessment. *The assessment had not been accurate.</p> <p>Review of the provider's 6/11/14 Use of Restraints policy revealed:</p>	F 221		

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F 221	Continued From page 16 *Prior to placing a resident in restraints there shall be a pre-restraining assessment and review to determine the need for restraints. *The assessment shall be used to determine possible underlying causes of the problematic medial symptoms and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that might improve the symptoms. *Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative.	F 221			
F 222 SS=G	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS  The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.  This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on record review and interview, the provider failed to ensure an anti-anxiety medication was administered to one of one sampled resident (2) for the appropriate indications. Findings include:  1. Review of resident 2's complete medical record revealed: *He had been admitted on 10/7/13. *His diagnoses included: -Dementia (memory loss). -Anxiety state. -Right hip fracture on 3/8/14 related to a fall. *Admitted to Hospice services on 8/28/14 related to his dementia.	F 222	1.The clinical record and drug regimen for Resident 2 was reviewed. There was a brief sedation effect that had resolved and no ongoing harm was identified. The care plan was updated with specific indications for use of the psychoactive medications and non-pharmacological interventions. The clinical records, drug regimen, and care plan for all residents who are prescribed psychoactive medications were reviewed for appropriate dosage and indications for use, and non-pharmacological interventions. 2. All licensed nursing staff were educated regarding checking for	10/10/14	

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F 222	<p>Continued From page 17</p> <p>*On 8/28/14 he had a physician's order for Ativan (anti-anxiety medication) 2 milligrams (mg)/milliliter (ml) administer 0.25 ml (one-half mg) to 0.5 ml (1 mg) sublingually (under the tongue) every four hours as needed for anxiety.</p> <p>Review of resident 2's Antipsychotic Monitoring Tool sheet revealed: *On 8/28/14 at 8:00 p.m. he had been given 1 ml of Ativan sublingually for displaying "agitation with cares." *On 8/29/14 at 2:00 a.m. he had been given another 1 ml of Ativan for displaying "agitation with cares." *Ativan 1 ml was equivalent to 2 mg of Ativan, which would mean the resident had received twice the physician's ordered dose.</p> <p>Interview on 9/3/14 at 4:00 p.m. with the director of nursing (DON) regarding the above record review revealed: *She had been unaware there was an incorrect dose of Ativan administered to resident 2. *She agreed the resident had been given twice the physician ordered dose of Ativan. *The resident could have been severely injured with that incorrect dose of Ativan.</p> <p>Interview on 9/4/14 at 10:30 a.m. with the DON regarding licensed practical nurse (LPN) L that had been involved in administering the incorrect dose of Ativan to resident 2 revealed: *She had spoken to LPN L on the phone regarding the medication error. *LPN L had stated she had not been feeling well that night. *That had been LPN L's reason for the medication error.</p>	F 222	<p>dosage instructions, appropriateness and assessment of the need for psychoactive medication, and care plan development and implementation of non-pharmacological interventions.</p> <p>3. Pharmacy consultant will continue to do drug regimen reviews monthly. At monthly QAPI meetings, the Director of Nursing or designee will report on an audit of the Medication Administration Record, the behavior monitoring documentation, and the Pharmacist's Drug Regimen Review for all residents who have prescribed psychoactive medications to verify appropriateness and accuracy of the administration of the medications. These audits will occur weekly for 90 days, and then bimonthly for 90 days. When the QAPI committee determines otherwise, frequency of audits may be changed. Based on findings of the review,</p>		

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F 222	<p>Continued From page 18</p> <p>Anonymous interview on 9/10/14 at 3:00 p.m. regarding resident 2 revealed: *The next day after he had received the Ativan he was hard to arouse. *He had gone all day without eating, because he had been too sleepy. *He had slept most of the next day after he had received the Ativan.</p> <p>Telephone interview on 9/11/14 at 11:30 a.m. with LPN L and the business manager revealed: *She was aware a medication error had occurred with resident 2's Ativan. *She stated she had not been feeling well that night, and that was the reason she had administered the incorrect dose of Ativan. *Resident 2 was swinging and attempted to hit her and another co-worker as they were attending to him. She administered the Ativan to stop him from hitting at them.</p> <p>Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing 8th Ed., St. Louis, Mo., 2013, p. 582, revealed: **Administering medications to patients requires knowledge and a set of skills that are unique to a nurse. You first assess that the medication ordered is the correct medication. *A medication error can cause or lead to inappropriate medication use or patient harm. Medication errors include inaccurate prescribing, administering the wrong medication, giving the medication using the wrong route or time interval, and administering extra doses or failing to administer a medication. Preventing medication errors is essential. Because nurses play an essential role in preparing and administering medications, they need to be vigilant in preventing errors. Medication errors are related to</p>	F 222	performance improvement actions will be implemented.		

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F 222	Continued From page 19 practice patterns, health care product design, or procedures and systems such as product labeling and distribution."	F 222		
F 224 SS=E	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to ensure five of eight sampled residents (2, 6, 7, 8, and 9) received their baths every week. Findings include:  1. Review of resident bathing records for June, July, and August 2014 revealed: *Resident 2 had not received a bath or shower for eight days from 8/12/14 through 8/20/14. *Resident 6 had not received a bath or shower for four weeks from 7/8/14 through 8/6/14. *Resident 7 had not received a bath or shower for twelve days from 6/25/14 through 7/7/14 and nine days from 7/7/14 through 7/16/14. *Resident 8 had not received a bath or shower for two weeks from 7/11/14 through 7/25/14 and from 8/8/14 through 8/22/14. *Resident 9 had not received a bath or shower for two weeks from 8/11/14 through 8/25/14. *There had been no documentation as to why the	F 224	1.By observation, interview and review of the clinical records for Residents, 2, 6, 7, 8, and 9, it was determined that there were no negative outcomes for these residents related to not having weekly showers or baths. All residents who are able to complete the Brief Interview for Mental Status were interviewed regarding bathing preferences. 2.The consistently assigned CNAs will give residents their showers or baths. A shower/bathing policy was developed to describe the process for identifying preferences for shower or bath and frequency and time of day for bathing. A shower/bathing log was developed for the CNAs to document completion of each resident's shower/bath, nail care, and weight. Weekly skin checks will be completed during bathing by the	10/10/14

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NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105</b>		
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F 224	Continued From page 20 above residents had gone longer then seven days for a bath or shower.  Confidential interview on 9/3/14 at 11:00 a.m. with two random residents revealed they had not received a shower or a bath for two weeks.  Confidential interview on 9/3/14 at 5:00 p.m. with certified nursing assistant (CNA) revealed baths were supposed to have been done at night in the memory support unit. The bathes not been getting done because there was only one staff person working at that time.  Confidential interview on 9/4/14 at 10:00 a.m. with a CNA revealed baths for all residents in the center and the east halls were not getting done in a timely manner because of staffing issues.  Interview on 9/9/14 at 2:55 p.m. with the administrator and the director of nursing revealed they had not monitored the bathing records. They were unaware baths had not been getting done one time per week.  Review of the provider's 5/15/13 Shower/Tub Bath policy revealed there was no process for: *Scheduling resident's bath days. *Documenting when baths were not given.	F 224	nurse and checked off on the skin check sheet on the Treatment Administration Record (TAR). All nursing staff were educated on the shower/bathing process, assignments, and completion of the log and the TAR. 3. At monthly QAPI meetings, the Director of Nursing or designee will provide a report on an audit of the shower/bathing log and TAR for completion of showers/baths, nail care, weights, and skin checks. These audits will occur weekly for 90 days, and then bimonthly for 90 days. Based on findings of the report, performance improvement actions will be implemented. The reports on the showers/bathing process will occur until the QAPI committee determines otherwise.		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	F 225			

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F 225	<p>Continued From page 21</p> <p>of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on record review, interview, and policy review, the provider failed to: *Thoroughly investigate one of one newly hired nursing staff (L) who had allegations of simple assault against another person.</p>	F 225	<p>1. Reference checks were completed for employees L, CC, DD, EE, FF, GG, HH, and II. Review of the court documents for Employee L revealed the charge did not restrict her from employment. Employee files were reviewed for all employees hired and still working since June 2014 and were determined to have reference checks completed.</p> <p>2. The Administrator or human resources representative will complete reference checks and investigate past convictions identified on through criminal background checks before an employee is hired. The employment application form was revised on 9/17/14 to include professional references, current/ past employer, and permission to contact.</p> <p>3. The human resources representative will randomly audit two employee files for completion of reference checks and investigation into</p>	10/10/14	

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F 225	<p>Continued From page 22</p> <p>*Complete reference checks on eight of nine reviewed employees (CC, DD, EE, FF, GG, HH, L, and II).</p> <p>Findings include:</p> <p>1. Review of employee L's file revealed: *The person was hired on 7/30/14. *The criminal background check revealed: -Simple assault attempt to cause bodily injury. -Simple assault recklessly causes bodily injury. -Simple assault attempt to put another in fear of bodily harm. -Simple assault intentionally cause bodily injury. *There had been no reference checks completed by the provider.</p> <p>Interview on 9/10/14 at 11:30 a.m. with the administrator, business manager O, and the director of nursing regarding the above concerns revealed: *The administrator was unaware the employee had convictions pending for simple assault. *Business manager O had hired the individual without thoroughly investigating the results of the background check. She had not completed reference checks, because she did not have the time to do a thorough investigation. *The DON had been unaware of the situation. *All agreed the matter should have been taken care of prior to employment by the provider.</p> <p>2. Review of employee files CC, DD, EE, FF, GG, HH, L, and II revealed there had been no reference checks done prior to their employment with the provider. Those dates of hire for the above employees had dated back to February 19, 2014 through September 12, 2014.</p> <p>Review of the provider's June 2014 Abuse and</p>	F 225	<p>negative findings on the criminal background checks weekly for 90 days and then monthly for 90 days. Issues will be reported to the Administrator. The Administrator will provide a report during the monthly QAPI meeting. When the QAPI committee determines otherwise, frequency of audits may be changed. Based on findings of the report, performance improvement actions will be implemented.</p>		

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F 225	Continued From page 23 Neglect policy revealed: *The provider would protect the residents using a variety of techniques that would include but were not limited to: *Screening of potential people to hire: -"Prospective applicants to our facility will provide a list of references prior to employment. -The interviewing supervisor is required to verify a minimum of two of the applicant's references, specifically the most recent employers, by either phone call or in writing. -If the applicant is a licensed nurse or certified nursing assistant, the Board of Nursing will be contacted concerning any findings of abuse, neglect, or mistreatment of patients/residents or misappropriation of their property. -A criminal background check will be completed on all potential employees when offered employment."	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to investigate incidents of: *Missing jewelry for one of one sampled resident (33). *Missing money for one of one sampled resident	F 226	1. Interviews with Residents 9, 13, 33, and 34 determined that there was a satisfactory resolution to the grievances related to missing property or staff complaints. Review of the clinical records for Residents 2 and 38 determined there was no negative outcomes for these residents related to the unwitnessed incidents. All residents who are able to complete the Brief Interview for Mental Status were	10/10/14

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F 226	Continued From page 24 (9). *Staff accusations by two of two sampled residents (13 and 34). *Resident burn for one of one sampled resident (2). *Eloperments for one of one sampled resident (2). *An unwitnessed fall with an injury for one of one sampled resident (38). Findings include:  1. Review of the provider's incident and grievance reports revealed: *On 6/10/14 resident 33 had reported she was missing her wedding ring. *On 7/7/14 resident 32 had reported she was missing \$9.00 in one dollar bills. *On 6/20/14 a hospice worker had reported a certified nursing assistant (CNA) for being forceful with resident 13. *On 7/27/14 the family of resident 34 had made a complaint against a CNA. *There was no documentation that a thorough investigation had been completed for any of the above issues. Surveyor: 30170 2. Review of resident 2's complete medical record and incident reports revealed: *On 7/27/14 at 1400 (2:00 p.m.) he had triggered a door alarm on the center wing. He resided in the east wing. He had exited the building in his wheelchair. He had pushed himself through the doorway and down the hill causing him to fall over in wheelchair on his right side. The fall had caused a skin tear to his right wrist and a small abrasion to the outer aspect of his right knee. *There was no thorough investigation completed by the provider as to the reason a resident in a wheelchair had gotten outside while the door alarm had been sounding and then had fallen. *On 9/1/14 at 12:30 p.m. there had been a hot	F 226	interviewed regarding concerns or incidents related to potential abuse, neglect, mistreatment, misappropriation of resident a property, or injuries of unknown origin.  2. Reports of missing property will be addressed through the facility grievance process. If potential misappropriation is determined, the grievance will be addressed further through the abuse investigation process. An Incident/Occurrence report form was developed for all other suspicions and accusations of abuse, neglect, mistreatment, and injuries of unknown origin; and the policies were modified to address the investigation and documentation responsibilities.  3. At monthly QAPI meetings, the Administrator or designee will provide a report on a 100% audit of the Incident/Occurrence reports to verify timely notification, thorough investigation, and appropriate	10/10/14	

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F 226	Continued From page 25 coffee spill to his left inner upper thigh and the reddened area had measured 5 inches by 1 inch that was U-shaped. There was no investigation completed by the provider. Surveyor: 22452 3. Review of resident 38's 6/7/14 event report revealed: *She had been found sitting on the floor on her bottom in a room other than her own on 6/7/14 at 12:00 noon. *Her room was 315. *She was confused (memory loss). *She had a "goose egg" (bump) 5.0 by 3.0 centimeter area on the back of her head. *She had received oxycodone (narcotic pain medication) prior to being found on the floor. *There was twenty-four hour documentation indicating "No further injuries noted and no complaints." *There was no documentation the incident had been investigated.  Surveyor: 32335 4. Interview on 9/9/14 at 10:00 a.m. with licensed social worker F revealed: *Any staff issues related to abuse and neglect were to be investigated by the director of nursing (DON). *Sometimes she started the initial report regarding the staff accusation and then turned it over to the DON. *The nursing staff were to investigate the falls. *She was responsible for investigating missing money, missing jewelry, and resident-to-resident abuse. *The staff were not interviewed regarding the missing wedding ring. *She had interviewed staff regarding the missing money but had not documented those interviews.	F 226	resolution occurred. These audits will occur weekly for 90 days, and then bimonthly for at least 90 days. When the QAPI committee determines otherwise, frequency of audits may be changed. Based on findings of the report, performance improvement actions will be implemented.	

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F 226	<p>Continued From page 26</p> <p>*Residents 32 and 33 were not compensated for the missing wedding ring or the missing money.</p> <p>5. Interview on 9/9/14 at 2:35 p.m. with the administrator and the DON revealed: *Staff accusations should have been investigated by the DON. *The DON had started employment on 8/14/14. *The staff accusations regarding residents 13 and 34 had not been investigated by the prior DON or the administrator. *They had not followed their policy regarding investigations of abuse and neglect.</p> <p>Surveyor: 30170</p> <p>6. Review of the provider's 11/8/12 Guidelines for Nursing Documentation policy revealed: **"Considerations for documentation for the following: *Accidents and or Incidents -Circumstances surrounding the accident or incident; what led up to it. -Where the accident or incident took place. -Date and time of the accident or incident. -Name of the witnesses and their account of the accident or incident. -Resident's account of the accident or incident. -Time the physician was notified as well as the time the physician responded. -Date and time the family was notified of the accident or incident. -Condition of the resident following the accident or incident. -Disposition of the resident following the accident or incident. -All pertinent observations concerning the accident or incident."</p> <p>Surveyor: 32335</p>	F 226		

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F 226	Continued From page 27 Review of the provider's June 2014 Abuse Investigations policy revealed: **Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident. *The individual conducting the investigation will, at a minimum: -Review the completed documentation forms. -Review the resident's medical record to determine events leading up to the incident. -Interview the person(s) reporting the incident. -Interview any witnesses to the incident. -Interview the resident (as medically appropriate). -Interview the resident's attending physician as needed to determine the resident's current level of cognitive (memory) function and medical condition. -Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. -Interview the resident's roommate, family members, and visitors. -Interview other residents to whom the accused employee provides care or services. -Review all events leading up to the alleged incident. *Witness reports will be obtained in writing. Witnesses will be required to sign and date such reports. *The individual in charge of the abuse investigation will notify the ombudsman [resident advocate] that an abuse investigation is being conducted. *The ombudsman will be invited to participate in the review process. *The administrator will keep the resident and his/her representative (sponsor) informed of the	F 226		

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F 226	Continued From page 28 progress of the investigation."	F 226		
F 241 SS=E	<b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b>  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 A. Based on observation, record review, interview, and policy review, the provider failed to answer call lights in a timely manner for two of two random residents (35 and 42). Findings include:  1a. Interview on 9/3/14 at 11:00 a.m. with a group of ten random residents revealed on a good night call lights were answered in thirty to forty-five minutes. On a bad night it took anywhere from one to two hours to be answered.  Surveyor: 33265 b. Interview on 9/6/14 at 11:45 a.m. with resident 35 revealed: *She required two staff to assist her in transferring using the Hoyer lift (mechanical device that lifts residents). **"Only had one CNA [certified nursing assistant] on last night." "I need two people to help me." "Had to wait forever to go to the bathroom."  Interview on 9/7/14 at 7:59 p.m. with resident 35 revealed: *She had put her call light on at 6:30 p.m.	F 241	1. A. Interview of Residents 35 and 42 determined there was no negative outcome related to timeliness of call light response. Residents who have had delayed call light response times greater than 10 minutes will be identified from a call light system audit for the past 30 days. Those residents will be interviewed to determine if there were any negative outcomes. B. Interview with Resident 7 determined there was no negative outcome related to hearing impaired communication techniques. The clinical records for residents who are hearing impaired or dysphasic will be reviewed to ensure alternative communication techniques are documented and care planned. C. Review of the clinical record for Resident 13 determined that there was no negative outcome related to timely assistance with mealtime.	10/10/14

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F 241	Continued From page 29 following the evening meal for the assistance of one person to place a bedpan under her. *She finished and put her call light on at 6:40 p.m. to be taken off the bedpan. *She received assistance to get off the bedpan at 7:55 p.m. *She was in pain and was told there was a red area on her buttocks (bottom) where the bedpan had been.  Surveyor: 32335 c. Observation and interviews on 9/8/14 from 4:47 p.m. through 5:45 p.m. regarding resident 42 revealed: *At 4:47 p.m. this surveyor observed an activated call light for resident 42 in his room. *At 4:50 p.m. the medical records staff person went into the room and changed the call light to green indicating the resident was being helped. She left the room right away. *At 4:55 p.m. registered nurse (RN) A entered the room and assisted resident 42's roommate. *Interview at that time with RN A revealed she had not asked resident 42 what he needed as it appeared someone was helping him. *Interview at 5:00 p.m. with the resident revealed he thought the person who had answered the light was telling someone of his request. -He wanted nicotine gum and a nebulizer treatment. *At 5:20 p.m. the call light remained green, and he had not yet received what he had requested. -RN A entered the room at that time to give his roommate his medication. -She had asked resident 42 a question and stated "maybe they told the med [medication] tech [technician]." *At 5:25 p.m. a CNA delivered resident 42's food tray.	F 241	The clinical records for residents who are dependent on staff for eating assistance were reviewed to determine if there were negative outcomes related to mealtime assistance. D. Observation of Residents 1, 6, and 9 determined there was no negative outcome from nail care services. Observation of nail grooming for all residents will occur during daily rounding to identify any other residents with potential negative outcome. 2. All staff will be educated on the use of the call light system and will be instructed that all staff must answer lights, identify the resident need, and either respond or summon the appropriate assistance. Through an appropriate means, per resident preference, all staff will be informed about alternative communication techniques. The meals for dependent residents will not be plated and served until a staff person is available to assist		

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F 241	<p>Continued From page 30</p> <p>*At 5:27 p.m. RN A had turned off the call light without providing the resident with the nicotine gum or the nebulizer treatment.</p> <p>*Interview at 5:30 p.m. with the resident revealed he still had not gotten what he had requested. He stated "my chest is feeling tight and I really need my neb [nebulizer] treatment."</p> <p>*Interview at 5:33 p.m. with RN A revealed she still had not gotten resident 42 what he had requested.</p> <p>*Interview at 5:45 p.m. with resident 42 revealed he had received the nicotine gum and the nebulizer treatment approximately five minutes earlier.</p> <p>*The observation by this surveyor had been fifty-three minutes before the resident received his requested items.</p> <p>d. Review of the provider's call light data collection report from 8/26/14 through 9/8/14 revealed:</p> <p>*There was no data from 9/2/14 through 9/8/14.</p> <p>*The data collection system had stopped working for those dates.</p> <p>*They were not aware the system had stopped working until surveyors had requested the data on 9/8/14.</p> <p>*The data for the three situations mentioned above was not available due to the system not working.</p> <p>*Resident 42's call light had been activated on 9/8/14 prior to the system re-starting.</p> <p>-It was unclear at what time he had activated his call light.</p> <p>*The report indicated that all the call lights tracked had been activated in the bedroom.</p> <p>*There were no call lights on the report that had been activated from a bathroom.</p>	F 241	<p>them with eating. Ancillary nursing and other disciplines will be assigned responsibilities to assist with mealtime activities for all three meals Monday through Sunday. A shower/bathing log was developed for the CNAs to document completion of each resident's shower/bath, nail care, and weight.</p> <p>3. At monthly QAPI meetings, the Administrator or designee will review call light response times weekly for 90 days, then bimonthly for 90 days, and then monthly ongoing to identify any response times in excess of 10 minutes to identify patterns of occurrence, investigate further to determine the contributing factors for the delay(s), and determine if there is a need for changes to staffing patterns. All changes of condition, including new or revised needs for an alternative communication technique, will be reported during the daily (M-F) clinical stand-up meeting with the</p>		

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F 241	Continued From page 31 Interview and record review on 9/9/14 at 3:15 p.m. with the administrator and the director of nursing (DON) revealed: *They had no specific timeframe for when a call light should have been answered. *They stated it "depends on what is going on in the facility." *The call light data report tracked the date, time, room number, location, staff response time, and how long the light had been green before being turned off. *Staff were to hit the button and turn the light to green when they were in assisting the resident. *Non-nursing staff had been instructed to check on the residents with call lights activated, but they should not turn the light to green. *The medical records staff person should not have turned resident 42's call light to green. *The call light report had N/A (not applicable) multiple times throughout the report for how long staff were in the room assisting the resident. *They figured staff were turning the light off when entering the room instead of changing it to green. *The DON was not aware of how the call light system worked regarding turning the light to green and had not received any training on the call lights. *No follow-up education had been provided to staff regarding how to use the call light system. *The administrator ran the report once a month to review the average time for answering the call lights. *He did not utilize the reports unless there was a concern or complaint. *The reports were not reviewed for quality assurance. *On 9/1/14 in room 322 the call light had been activated for two hours and twenty-three minutes. When asked if that was too long for a call light to	F 241	interdisciplinary team (IDT). The Registered Dietitian consultant will audit the mealtime process for a minimum of three meals a week of all three mealtimes weekly for 90 days, and then bimonthly for 90 days, to ensure timely assistance is provided for dependent residents. When the QAPI committee determines otherwise, frequency of audits may be changed or discontinued unless concerns are identified related to the nutritional status of residents. The Director of Nursing or designee will provide a report on a review of the shower/bathing log and TAR for completion of showers/baths, nail care, weights, and skin checks. These audits will occur weekly for 90 days, and then bimonthly for 90 days. The reports on the showers/bathing process will occur until the QAPI committee determines otherwise.	

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F 241	<p>Continued From page 32</p> <p>be activated without staff response they both stated "it would depend on what is going on in the facility." Neither the administrator nor the DON would agree that it was too long.</p> <p>A call light policy had been requested by this surveyor but it had not been provided by the time of the survey exit.</p> <p>Review of the provider's April 2013 Quality of Life - Dignity policy revealed "Staff shall promote dignity and assist residents as needed by promptly responding to the resident's request for toileting assistance."</p> <p>B. Based on observation, interview, record review, and policy review, the provider failed to follow the resident's care plan and use pen and paper to communicate with him for one of one sampled resident (7) with a hearing impairment. Findings include:</p> <p>1. Observation and interview on 9/3/14 at 10:00 a.m. with resident 7 revealed he: *Had a hearing impairment. *Could not understand this surveyor when spoken to. *Could read notes and answer questions that were written on a note pad. *Was very friendly and talkative.</p> <p>Review of resident 7's 6/25/14 Minimum Data Set (MDS) assessment revealed his ability to hear was highly impaired.</p> <p>Review of resident 7's undated care plan revealed: *He had a cognition (thinking) and communication goal with the following</p>	F 241		

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F 241	<p>Continued From page 33</p> <p>interventions:</p> <ul style="list-style-type: none"> <li>-I am able to read and I communicate best if you write things down for me.</li> <li>-I am able to verbalize my responses.</li> <li>-I do not like to use a dry erase board.</li> <li>-I prefer you write communications with me in my notebook, which works very well to communicate with me.</li> <li>-This way I can look back and remind myself of conversations I have had.</li> <li>-My niece will keep me supplied with notebooks, just call her if I need more.</li> <li>-Encourage me to make as many decisions on my own as I am able."</li> </ul> <p>Observation and interview on 9/4/14 at 8:25 a.m. with CNA K regarding resident 7 revealed she:</p> <ul style="list-style-type: none"> <li>*Had assisted him with getting up that morning.</li> <li>*Had not used the pen and paper to communicate with him.</li> <li>*Thought he could read lips.</li> <li>*Asked him if he wanted to go to breakfast. He responded with "yes, I am cold."</li> <li>*Wrote that same question down on the paper per request of this surveyor and he stated "well sure, I like breakfast."</li> <li>*Agreed the last notes in the notebook would have been from family and the hospital staff when he had his surgical procedure.</li> </ul> <p>Review of resident 7's interdisciplinary notes revealed the suprapubic catheter surgery was on 8/27/14.</p> <p>Interview on 9/9/14 at 10:00 a.m. with licensed social worker F revealed staff should have been using paper and pen to communicate with resident 7.</p>	F 241		

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F 241	<p>Continued From page 34</p> <p>Observation and interview on 9/9/14 at 11:10 a.m. with RN A in resident 7's room revealed she:</p> <ul style="list-style-type: none"> <li>*Had gone into his room to change a dressing.</li> <li>*Had not used the paper and pen to communicate with him.</li> <li>*Stated "he has selective hearing and can hear when he wants to."</li> </ul> <p>Review of the provider's April 2013 Quality of Life - Dignity policy revealed:</p> <ul style="list-style-type: none"> <li>*"Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality.</li> <li>*Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self esteem and self-worth."</li> </ul> <p>Surveyor: 33488</p> <p>C. Based on observation and interview, the provider failed to ensure one of one resident (13) who was dependent on staff for nutrition and hydration was fed in a timely manner. Findings include:</p> <p>1. Observation on 9/9/14 from 11:30 a.m. through 1:15 p.m. of resident 13 during lunch revealed:</p> <ul style="list-style-type: none"> <li>*She was brought into the dining room at 11:30 a.m.</li> <li>*At 12:20 p.m. the resident's food was brought to her table and set in front of her by staff.</li> <li>*Only one staff member, nurse aide (NA) JJ, had been available to assist one sampled resident (13) and seven unidentified dependent residents to eat.</li> <li>*At 12:30 p.m. she attempted to grab ground beef with her fingers.</li> <li>*She then pulled at the tablecloth in an attempt to get silverware that was placed out of her reach.</li> <li>*At 12:50 p.m. the resident dipped her napkin in her mashed potatoes and proceeded to lick her</li> </ul>	F 241	

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F 241	<p>Continued From page 35</p> <p>napkin.</p> <p>*At 12:55 p.m. an unidentified dietary staff member told this surveyor "someone is supposed to feed her; I can't, they (the provider) won't let me."</p> <p>*The resident stuck her fingers in her food at 1:00 p.m. and attempted to eat her cloth napkin at 1:05 p.m.</p> <p>*At 1:10 p.m. NA JJ was able to begin feeding resident 13.</p> <p>*She had not warmed the food or checked the temperature prior to feeding the resident.</p> <p>Interview on 9/9/14 at 2:45 p.m. with NA JJ regarding the above observation revealed she:</p> <p>*Had no idea it had been fifty minutes from the time she had been served to having been assisted to eat.</p> <p>*Was unable to reheat the resident's food as she had no reheating source available in the east dining area.</p> <p>*Was unaware if the food would have been safe to eat or was palatable (tasted okay) to the resident.</p> <p>*Had little help from other staff to assist her in feeding dependent residents.</p> <p>*Stated they (the provider) were short staffed and the above observation was not uncommon.</p> <p>*Agreed the resident's dignity had not been upheld.</p> <p>D. Based on observation, record review, interview, and policy review, the provider failed to do nail care for three of three sampled residents (1, 6, and 9). Findings include: Surveyor: 22452</p> <p>1. Observation on 9/2/14 at 6:30 p.m. of resident 1 revealed all her fingernails were very long and had dark brown material under them.</p>	F 241			

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F 241	<p>Continued From page 36</p> <p>Continued observation during the survey from 9/3/14 through 9/11/14 revealed no change in her fingernails.</p> <p>Review of resident 1's undated care plan revealed: *She had memory loss. *She was dependent on staff for most of her activities of daily living. *Bathing and nail care was not addressed. Surveyor: 32331</p> <p>2. Observation on 9/3/14 at 9:40 a.m. of resident 6 revealed he: *Was sitting in his room in his wheelchair. *Had long and brown material under his fingernails. *Had two partial amputated fingers.</p> <p>Review of resident 6's medical record revealed: *On 8/26/14 by medical doctor (MD) I's Physician's Progress Note "Also noted terrible fingernails!" *On 8/26/14 by MD I an order for "Please trim fingernails."</p> <p>Observation on 9/8/14 at 5:20 p.m. of resident 6's fingernails revealed: *No change in his fingernails. *He continued to have long and dirty fingernails on those fingers with nails.</p> <p>Interview on 9/9/14 at 3:22 p.m. with licensed practical nurse (LPN) AA regarding resident 6's fingernails revealed she: *Had noted the physician's order on 8/26/14 to trim his fingernails. *Had trimmed his fingernails on 8/26/14.</p>	F 241	

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F 241	Continued From page 37 Interview on 9/10/14 at 9:00 a.m. with Minimum Data Set (MDS) coordinator J regarding resident 6's fingernails revealed: *It was her expectation the nails would have been trimmed as needed weekly with his bath. *That was to have been completed by the certified nursing assistants (CNA) who provided his baths. *She had expected that to have been done as needed. Surveyor: 33265 3. Observation on 9/4/14 at 8:15 a.m. in resident 9's room with RNA revealed: *He requested to have his nails trimmed. *He showed his long fingernails to RN A and this surveyor. *RN A responded that she used to have time to trim fingernails. *The fingernails remained untrimmed.  4. Review of the provider's April 2013 Quality of Life - Dignity policy revealed residents should have been assisted in grooming as they were to have been groomed including care of fingernails and toenails.	F 241			
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Surveyor: 32332	F 248	1. Review of the clinical records for Resident 3 and 10 were reviewed on 9/22/14 and those residents were determined to have no negative outcome related to lack of activities. Clinical records for residents in isolation and those who do not attend group activities were reviewed.	10/10/14	

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F 248	<p>Continued From page 38</p> <p>Based on observation, interview, record review, and policy review, the provider failed to:</p> <ul style="list-style-type: none"> <li>*Ensure an effective activity program for one of one sampled resident (10) on isolation precautions (keeping resident in her room to prevent the spread of infection).</li> <li>*Ensure activities were provided for one of four sampled residents (3).</li> </ul> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Record review of resident 10 revealed: <ul style="list-style-type: none"> <li>*She was placed on isolation precautions on 7/28/14 due to an infection.</li> <li>*She was not allowed out of her room.</li> <li>*Her 7/17/14 activity care plan revealed: <ul style="list-style-type: none"> <li>- "I am weak and do not want to participate in groups."</li> <li>- "I want you to visit me twice weekly for sensory stimulation [activity that engages the five senses]."</li> <li>- "Visit me, lotion my arms, read to me, play music."</li> </ul> </li> </ul> </li> </ol> <p>Review of the provider's one-to-one program schedule revealed resident 10 was to have received one-to-one visits weekly on Monday by the activity staff.</p> <p>Random observations of resident 10 throughout the survey from 9/2/14 through 9/10/14 revealed:</p> <ul style="list-style-type: none"> <li>*No activity visits had been witnessed.</li> <li>*Resident 10 had music playing in her room on only one occasion.</li> </ul> <p>Interview on 9/4/14 at 8:20 a.m. with activity aide PP regarding resident 10 revealed:</p> <ul style="list-style-type: none"> <li>*She tried to visit the resident two to three times/weekly.</li> <li>*She had documented all visits on the care tracker.</li> </ul>	F 248	<p>2. The Activity Director will participate in the daily (M-F) clinical stand-up meeting with the interdisciplinary team (IDT) so that she is aware of all changes of condition, including residents on isolation, in order to individualize activities for those residents accordingly. For those residents who are not able or choose not to participate in daily group activities, the Activity Director will plan a program of daily individualized activities. The CNA care cards will include the daily individualized activities. The CNAs and activity staff will collaborate to ensure those daily activities occur and are documented on participation records.</p> <p>3. The Activity Director or designee will audit the participation records for five residents per week for twelve weeks, and then five residents per month. The reports on activity participation will continue until the QAPI committee determines otherwise.</p>	

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F 248	<p>Continued From page 39</p> <p>*The resident was to have been visited more before she came down with an infection. "But then we needed to gown and glove and we weren't sure what to do."</p> <p>Interview on 9/4/14 at 8:35 a.m. with the activity coordinator revealed:</p> <p>*Resident 10 had been receiving more one-to-one activity before her infection. She was on hospice, and the hospice aide came five times/week.</p> <p>*She had agreed the hospice aide was to have been performing personal care rather than doing an activity.</p> <p>*She agreed all hospice visits were to have been supplemental to activity the resident received from the provider.</p> <p>*She agreed residents who were isolated from others should have received more activity visits.</p> <p>Review of the provider's 10/28/13 Activity Programs and Services policy revealed residents on a "full room visit program" were to have received, at a minimum, three room visits per week.</p> <p>Surveyor: 30170</p> <p>2. Review of resident 3's activities report from June 2014 through September 10, 2014 and interview on 9/10/14 at 8:30 a.m. with the activities director revealed:</p> <p>*There was no documentation any activities had occurred for the resident since July 10, 2014.</p> <p>*She was sure he had attended some activities.</p> <p>*She confirmed if the activity was not documented it appeared as if no activity had occurred.</p> <p>3. Review of the provider's 10/28/13 Individual Activities and Room Visit Program revealed:</p>	F 248		

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F 248	Continued From page 40 *Individual activities would have been provided for those residents whose situation or condition prevented participation in other types of activities, and for those residents who had not wished to attend group activities. *The activities program provided individualized activities consistent with the overall goals of an effective activities program. The activities offered were reflective of the resident's individual activity interests, as identified in the activity assessment, progress notes, and the resident's comprehensive care plan.  Review of the provider's 10/28/13 Activity Programs and Services policy revealed: *Activity programs designed to meet the needs of each resident were available on a daily basis. -The activity programs were designed to encourage maximum individual participation and were geared to the individual resident's needs. -Attendance and participation was recorded for every resident in a group and individual activities on a daily basis. *The activities coordinator was responsible for maintaining appropriate departmental documentation.	F 248		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT  The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  This REQUIREMENT is not met as evidenced by:	F 252	1. A letter was sent on 10/1/14 to the family members/responsible parties for each resident on the memory care unit requesting them to send or bring resident memorabilia to put in shadow boxes to increase the homelike atmosphere. The facility	10/10/14

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F 252	<p>Continued From page 41</p> <p>Surveyor: 32335</p> <p>Based on observation, interview, and policy review, the provider failed to ensure a homelike environment in one of one memory care unit. Findings include:</p> <p>1. Random observations throughout the survey from 9/2/14 through 9/11/14 of the memory care unit revealed:</p> <ul style="list-style-type: none"> <li>*There were eleven residents who resided in the memory care unit.</li> <li>*There were yellow sticky notes with resident names on the individual room doors.</li> <li>*None of the rooms had room numbers to identify which room was which.</li> <li>*Four randomly observed residents' rooms were not personally decorated or homelike.</li> <li>*All of the rooms were painted white.</li> <li>*There was not a separate living room area.</li> <li>*The dining room was where they ate, watched TV, and participated in activities.</li> <li>*There were no couches in the unit.</li> <li>*The door to the courtyard was locked.</li> </ul> <p>Interview on 9/4/14 at 10:15 a.m. and again on 9/10/14 at 7:50 a.m. with medication technician S revealed:</p> <ul style="list-style-type: none"> <li>*They had been working on replacing the door numbers for a few months.</li> <li>*She was unaware of when that project would be completed.</li> <li>*They always kept the door to the courtyard locked unless they had an activity outside.</li> <li>*There was one resident who had it care planned that she could not have personal belongings in her room due to her behaviors.</li> <li>*She was not sure why the other residents' rooms were not decorated.</li> <li>*Sometimes certain residents wandered and</li> </ul>	F 252	<p>will decorate rooms and shadow boxes for those residents who do not receive resident memorabilia.</p> <p>2. The facility policy and admission packet will be revised to tell residents and family members/responsible parties that they are encouraged to bring in personal decorations, belongings, etc. to personalize their rooms. An audit tool related to homelike environment and accommodation of needs will be created. Staff were educated regarding this change in policy and the importance of helping the resident safeguard their personal belongings.</p> <p>3. Auditing for a homelike environment and accommodation of needs will be done for five rooms a week by a team that includes the Social Services Coordinator and members of the nursing and housekeeping staff. The Social Services Coordinator will report on the results of those audits at the monthly QAPI meeting.</p>		

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F 252	Continued From page 42 would take things out of the rooms. *Many of the residents had also taken things off the walls before and that was why she thought there were no decorations on the walls in the residents' rooms. *She had never approached family about bringing in personal items for the residents. *She thought social service designee YY who had been assigned to the memory care unit would have contacted the families about decorating the residents' rooms.  Several attempts were made on 9/10/14 to speak with social service designee YY assigned to the memory care unit, but she was unavailable.  An interview with the director of nursing was not conducted, as she was new to her position.	F 252	The frequency of reports on homelike environment will continue as directed by the QAPI committee.		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278	1. Review of clinical record for Residents 3, 14, and 44 determined there was no negative outcome related to inaccurate assessment. All residents could be at risk for negative outcomes related to inaccurate assessments. 2. MDS Case Managers were educated regarding timely and accurate monthly nursing summaries, assessment of potential physical restraints with the use of chair and bed equipment, and accurate coding of	10/10/14	

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F 278	<p>Continued From page 43</p> <p>subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on observation, interview, record review, and policy review, the provider failed to ensure: *A monthly nursing assessment had been completed for one of one sampled resident (3) for July 2014. *An accurately documented monthly nursing assessment for August 2014 for one of one sampled resident (3) who had an acute skin condition that had started on 7/10/14. *An accurate assessment had been done for one of one sampled resident (14) who had been using a seat belt (seat belt on the wheelchair to prevent from falling or sliding out of wheelchair) . *Accurate coding for ambulation and activities of daily living (ADL) for one of one sampled resident (44). Findings include:</p> <p>1a. Review of resident 3's complete medical record revealed: *He had been admitted on 10/14/11. *He was re-admitted in February 2014. *His diagnoses included: -Acute renal failure.</p>	F 278	<p>the self-performance of resident activities of daily living. One MDS Case Manager was designated as the coordinator of the MDS and care planning process.</p> <p>3. All changes of condition, including new or revised needs, will be reported during the daily (M-F) clinical stand-up meeting with the interdisciplinary team (IDT). Prior to the clinical stand-up meeting, the MDS Case Managers will review current assessment documentation to ensure the changes of condition have been documented and assessed. The MDS Case Managers will report to the Director of Nursing if documentation or assessment was lacking. The MDS Coordinator will report monthly at the QAPI meeting on effectiveness of the MDS and care planning process. These reports will occur until the QAPI committee determines otherwise.</p>	

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F 278	<p>Continued From page 44</p> <ul style="list-style-type: none"> <li>-High blood pressure.</li> <li>-Congestive heart failure.</li> <li>-Coronary artery disease.</li> <li>-Depression.</li> </ul> <p>*He had a rash to his scalp, neck, and his ears since 7/10/14.</p> <p>Observation on 9/3/14 at 9:15 a.m. of resident 3 revealed:</p> <ul style="list-style-type: none"> <li>*He had a large amount of scaling, dry skin on his scalp.</li> <li>*The scalp was reddened.</li> <li>*His ears had scabbed areas and appeared quite scaly and dry.</li> <li>*The back of his neck was quite pink in color and had some dry skin.</li> <li>*He was continually scratching at his ears and his head.</li> </ul> <p>b. Review of resident 3's Monthly Nursing Summary for August 30, 2014 revealed:</p> <ul style="list-style-type: none"> <li>*Under the section M skin conditions a nurse had documented there were no skin conditions.</li> <li>*There had been no documentation regarding his rash on his scalp, neck, and ears.</li> <li>*There was no documentation that a July 2014 Monthly Nursing Summary had been completed.</li> </ul> <p>c. Interview on 9/3/14 at 3:40 p.m. with registered nurse B regarding the monthly nursing summaries for resident 3 revealed:</p> <ul style="list-style-type: none"> <li>*The summaries were completed monthly on all residents.</li> <li>*A head-to-toe assessment was to have been completed by the nurse and then documented on the nursing summary form.</li> <li>*She was unable to find the July 2014 monthly nursing summary.</li> <li>*She agreed the August 2014 monthly nursing</li> </ul>	F 278			

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F 278	<p>Continued From page 45 summary was not correct and had not identified resident 3's skin issues.</p> <p>Review of the provider's 11/8/12 Guidelines for Nursing Documentation policy revealed nursing summaries were to include skin, hair, scalp, and nail conditions.</p> <p>Patricia A Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 350, revealed: *High-quality documentation and reporting are necessary to enhance efficient, individualized patient care. Quality documentation and reporting have five important characteristics: they are factual, accurate, complete, current, and organized." Surveyor: 32331</p> <p>2. Review of resident 14's medical record revealed: *He had been admitted on 7/3/14. *There was no physician's order for the use of the seat belt. *There was no assessment to indicate the use of the seat belt.</p> <p>Review of resident 14's 7/15/14 Interdisciplinary Progress Notes revealed: *Minimum Data Set (MDS) coordinator E had documented: -He had his own wheelchair with a seat belt. -He was unable to release the seat belt. -That seat belt was considered a restraint.</p> <p>Review of resident 14's admission MDS assessment on 7/10/14 revealed: *Restraints were coded zero (none) for all areas in section P under physical restraints. *Those areas used in the chair or out of the bed</p>	F 278		

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F 278	<p>Continued From page 46</p> <p>had included: -Trunk restraint. -Limb restraint. -Chair prevented rising. -Other.</p> <p>Interview on 9/9/14 at 9:10 a.m. with MDS coordinator E regarding resident 14's seat belt use revealed: *The seat belt had been considered a restraint. *That seat belt had been on him during the initial MDS assessment period. *It should have been coded on the 7/10/14 admission MDS assessment under: -Trunk restraint. -Chair prevented rising. *He would have been unable to release the seat belt when it was buckled. *She agreed the provider had not accurately assessed him for the seat belt. *She agreed he had not been accurately coded on the 7/10/14 admission MDS assessment for a physical restraint. Surveyor: 33265 3. Observation at random times on 9/9/14 between 3:30 p.m. and 5:40 p.m. revealed resident 44 required the assistance of two staff to transfer and move him from bed and wheelchair or from the wheel chair to the bathroom.</p> <p>Review of resident 44's complete medical record revealed: *The August 2014 updated care plan stated he: -Needed extensive assistance of one to two staff for all care. -Did not ambulate. -Needed the assistance of two staff to transfer. -Needed assistance to reposition every couple hours.</p>	F 278			

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F 278	Continued From page 47 *The 8/4/14 Minimum Data Set assessment (MDS) stated he: -Required no assistance while ambulating on the unit. -Required no assistance while ambulating off the unit. -Required no assistance with changing positions while in bed.  Interview on 9/10/14 at 1:40 p.m. with the director of nursing revealed she agreed the coding on the MDS assessment had not matched what was identified in the August 2014 care plan.  Review of the provider's 10/28/13 Resident Assessments (MDS) policy revealed all personnel who completed any portion of the MDS must sign to certify the accuracy of that portion of the assessment.	F 278			
F 279 SS=F	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279	1. Care plans for Residents 1, 2, 3, 5, 6, 7, 9, 12, 13, 14, 21, and 31 were reviewed and revised. Review of the clinical records determined there was no negative outcome related to the inaccurate care plans. All care plans over the next 90 days will be reviewed and revised for accuracy. 2. MDS Case Managers and licensed nurses were educated about the care planning process, in particular with changes of condition and new orders.	10/10/14	

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F 279	<p>Continued From page 48</p> <p>be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to update and revise 12 of 14 residents' (1, 2, 3, 5, 6, 7, 9, 12, 13, 14, 21, and 31) care plans to reflect their individual needs. Findings include:</p> <p>1. Observation on 9/2/14 at 6:30 p.m. of resident 1 revealed she: *Was sitting in her room in her wheelchair. *Had just returned to her room from the supper meal. *Had brown liquid on her face around her mouth. *Had dried stains on her blouse. *Had long and brown material under fingernails.</p> <p>Review of resident 1's undated care plan revealed: *"I want to look presentable when leaving my room to go to meals and activities." *"Please be sure I am clean and my clothes are clean." *"Thanks for helping me the way you do." *There was no documentation regarding her bathing or nail care needs. Surveyor: 33488</p> <p>2. Review of resident 12's medical record revealed: The resident's current care plan dated 7/28/14 had not addressed: *How much fluid the resident needed to maintain</p>	F 279	<p>Licensed nurses are designated with the responsibility of keeping the care plan, including the paper/ electronic and CNA care cards, up to date. One MDS Case Manager was designated as the coordinator of the MDS and care planning process.</p> <p>3. All changes of condition, including new or revised needs, will be reported during the daily (M-F) clinical stand-up meeting with the interdisciplinary team (IDT). Following the IDT, the MDS Case Managers will randomly audit a minimum of three care plans for those residents identified with changes of condition during the stand-up meeting to ensure the care plans and CNA care cards were updated. Any updates that have not occurred will be reported to the Director of Nursing who will provide corrective education, as needed. The MDS Coordinator will report monthly at the QAPI meeting on effectiveness of the MDS and care planning process.</p>	

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F 279	<p>Continued From page 49</p> <p>hydration. He was at risk for dehydration (not getting enough fluids).</p> <ul style="list-style-type: none"> <li>*Specific guidance to nurse aides regarding how often the resident needed to be repositioned.</li> <li>*His current pressure ulcer on his buttocks.</li> <li>*Specific toileting instructions for staff.</li> <li>*How much assistance he required to eat.</li> <li>*Updated treatments and interventions for care.</li> </ul> <p>3. Review of resident 13's medical record revealed: Current care plan dated 5/3/14 had not addressed:</p> <ul style="list-style-type: none"> <li>*How much fluid the resident needed to maintain hydration. She was at risk for dehydration (not enough fluid).</li> <li>*Specific guidance to nurse aides regarding how often the resident needed to be repositioned.</li> <li>*Identifying whether hospice or the provider was responsible for specific cares.</li> <li>*Her current pressure ulcers on her heels and buttocks/coccyx (tailbone).</li> <li>*Updated treatments and interventions required as changes occurred in her health.</li> <li>*Specific toileting instructions for staff.</li> <li>*How much assistance she required to eat.</li> </ul> <p>Refer to F314, findings 1, 2, and 3.</p> <p>Surveyor: 30170</p> <p>4. Review of resident 3's complete medical record revealed:</p> <ul style="list-style-type: none"> <li>*He had been re-admitted on 2/7/14.</li> <li>*He used a (continuous positive airway pressure machine (C-PAP) [machine that helps a person with sleep apnea (stops breathing) breathe better] at night and when he slept during the day.</li> <li>*He had a rash on his scalp, neck, and ears since 7/10/14.</li> </ul>	F 279	Based on report, further education and/or corrective action will be planned and carried out. These reports will occur until the QAPI committee determines otherwise.	

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F 279	Continued From page 50  Interview on 9/3/14 at 10:05 a.m. with certified nursing assistants C and D regarding resident 3 revealed he: *Would not let them comb his hair, because he stated his "scalp hurt." *Had refused to be shaved at times. *Had refused showers at times. *Had to be reminded to eat at times. *Wore his C-PAP machine at night and would put it on by himself during the day when he would take a nap.  His 2/14/14 care plan included the following areas: *Activities of daily living functions. *Urinary incontinence. *Advanced directives. *Pressure ulcer risk. *Activities. *Nutrition. *Communication. -Cognition. -Discharge Plans. *There had been no documentation or updates on the care plan regarding his C-PAP use; his current rash on his scalp, neck, and ears; or that he had any behaviors consisting of refusal of care.  5. Review of resident 2's complete care record revealed he: *Had been admitted on 10/7/13. *Had a history of reddened areas to his scrotal/rectal area. *Was receiving SensiCare #3 lotion to his scrotal/rectal area three times daily documented since 8/15/14 on his medication administration record.	F 279		

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F 279	<p>Continued From page 51</p> <p>*The care plan had not been updated to reflect his current treatment.</p> <p>6. Review of resident 21's complete care record revealed: *She had rapidly advancing dementia (memory issues). *She needed extensive assistance of one staff for eating her meals.</p> <p>Observation on 9/10/14 at 9:00 a.m. in the east dining room of resident 21 revealed she was sitting at a table by herself with her food in front of her. There were no staff around assisting her.</p> <p>Review of resident 21's 8/25/14 care plan revealed: *The areas addressed were: -Discharge plans. -Advanced directives. -Cognitive loss/psychosocial well-being. -Urinary incontinence. -Dehydration. -Pressure ulcer risk. -Falls. -Pain. *There had been no documentation in her care plan that she had required the extensive assistance of one person for her meals. Surveyor: 32331</p> <p>7. Review of resident 6's medical record revealed: *He was admitted on 2/1/14. *He had diagnoses that had included dementia (a mental change in the thinking process), osteoarthritis (a disease of the joints), and weakness. *He needed assistance with his daily care. *A physician's order on 5/8/14 "Up in Chair 1 1/2</p>	F 279			

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F 279	<p>Continued From page 52</p> <p>hours every AM &amp; PM Otherwise Bedrest for Healing."</p> <p>Observation and interview on 9/3/14 at 9:40 a.m. with resident 6 revealed he:</p> <ul style="list-style-type: none"> <li>*Was sitting in his room in his wheelchair.</li> <li>*Stated he slept in his bed not in his recliner.</li> </ul> <p>Review of resident 6's July 2014 care plan revealed:</p> <ul style="list-style-type: none"> <li>**I am unsteady and weak, and I need assistance transferring."</li> <li>**I recently slid out of my recliner."</li> <li>**I sleep in my recliner."</li> <li>*There was no documentation in his care plan regarding the physician's order for: <ul style="list-style-type: none"> <li>-Up in chair for one and one-half hours every a.m. and p.m.</li> <li>-Otherwise bedrest for healing.</li> </ul> </li> <li>*There was documentation in two different areas in his care plan that he slept in his recliner.</li> </ul> <p>Interview on 9/4/14 at 8:05 a.m. with certified nursing assistant (CNA) Y and CNA BB regarding resident 6 revealed:</p> <ul style="list-style-type: none"> <li>*He had not been sleeping in his recliner.</li> <li>*Both stated they had never observed him in his recliner.</li> </ul> <p>8. Review of resident 14's medical record revealed he:</p> <ul style="list-style-type: none"> <li>*Was admitted on 7/3/14.</li> <li>*Had diagnosis that included diabetes.</li> <li>*Had needed extensive assistance by staff with his care.</li> <li>*Had been on a tube feeding (tube directly into the stomach for nutrition) since admission.</li> <li>*Had lost 4.6 pounds (lb) or 3.6 percent of his weight the first month after admission.</li> </ul>	F 279		

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F 279	<p>Continued From page 53</p> <p>*He had a physician's order on 7/3/14 for "Weight Weekly."</p> <p>Review of resident 14's 7/22/14 care plan revealed: *"I want to maintain my weight." *"Monitor my weights." *There was no documentation in his care plan regarding the weight loss.</p> <p>Interview on 9/9/14 at 10:35 a.m. with the consultant registered dietitian regarding resident 14 revealed she: *Had been aware of his weight loss. *Knew his weekly weights had not been consistently obtained. *Expected his care plan to have been updated regarding his weight loss. Surveyor: 32332</p> <p>9. Review of resident 31's 8/6/14 care plan revealed: *He was at risk of developing pressure ulcers. *He needed assistance with walking and toileting. *He did not want to develop pressure ulcers.</p> <p>Review of his medical record revealed an 8/19/14 physician's order for DuoDerm (a skin dressing) to cover a red area on his coccyx (tailbone).</p> <p>Interview on 9/10/14 at 12:30 p.m. with the Minimum Data Set coordinator QQ regarding resident 31 revealed: *She stated a red area over a bone would have been classified as a stage one pressure area. *The care plan had not been updated to reflect that skin condition noted in the physician's orders of 9/19/14. Surveyor: 33265</p> <p>10. Observation on 9/3/14 from 5:15 p.m. through</p>	F 279		

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F 279	<p>Continued From page 54</p> <p>5:30 p.m. of resident 9 revealed: *His feeding tube (tube going directly into ) was not connected and the feeding pump was not infusing at 5:15 p.m. *His feeding tube was connected and the feeding pump was infusing at 5:30 p.m. *No one had entered his room during that time frame. *Resident had history of connecting and disconnecting his own feeding tube to the feeding pump.</p> <p>Review of resident 9's complete medical record revealed: *An interdisciplinary progress note on 6/15/14 at 5:00 p.m. that described the resident adjusting the rate of his feeding on his tube feeding pump. -Rate had been at 186 cubic centimeters (cc) per hour instead of the 85 cc per hour ordered. *Physician's orders to: -Check feeding tube placement before each feeding was dated 8/13/12. -Give a 200 cc flush of water through the feeding tube before and after each feeding was dated 8/12/13. -Jevity (nutritional solution to go through feeding tube in place of meals) 1.0 was to have been infusing at 85 cc per hour for sixteen hours (5:00 p.m. to 9:00 a.m.) was dated 5/27/14. -Jevity 1.0 was to have been infusing at 200 cc per hour for one and a half hours each noon was dated 6/23/14. -A 200 cc flush of water was to be one through the feeding tube every four hours was dated 7/23/14.</p> <p>Interview on 9/3/14 at 5:37 p.m. with RN B revealed she: *Was aware resident 9 had been starting and</p>	F 279		

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F 279	<p>Continued From page 55</p> <p>stopping his tube feeding himself.</p> <p>*Agreed there was no date or time documented on the Jevity solution container.</p> <p>*Agreed he might not have been getting the correct amount of Jevity or fluids ordered by the physician.</p> <p>*Agreed the assessments and water flushes might not have been done as ordered by physician.</p> <p>*Was not sure the date or time the current container of feeding solution had been hung.</p> <p>Observation on 9/8/14 from 12:00 p.m. (noon) to 1:07 p.m. of resident 9 revealed:</p> <p>*At 12:00 p.m. (noon), 12:21 p.m., and 12:40 p.m., his feeding tube was not connected or infusing.</p> <p>*At 12:44 p.m. his visitor left. The feeding tube was not connected or infusing at that time.</p> <p>*At 12:53 p.m. the feeding tube was connected to the solution and infusing at 250 cc per hour instead of the physician's ordered 200 cc per hour.</p> <p>*No one had entered the room since the visitor left.</p> <p>Interview on 9/8/14 at 1:08 p.m. with RN A regarding resident 9's feeding tube orders revealed she:</p> <p>*Believed his next feeding was at 5:00 p.m.</p> <p>*Stated he needed his every four hour 200 cc water flush done and proceeded to the resident's room.</p> <p>*Identified the feeding tube was infusing at that time.</p> <p>*She stopped the feeding pump and disconnected the feeding tube to administer the water flush.</p> <p>*She reconnected the feeding tube.</p>	F 279		

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F 279	<p>Continued From page 56</p> <ul style="list-style-type: none"> <li>*She restarted the feeding pump.</li> <li>*She asked the resident if he had connected his feeding tube and started his feeding. The resident stated he had. When asked why he stated no one came at noon to start it.</li> <li>*She was aware that resident 9 had been starting and stopping his feeding himself.</li> <li>*She agreed the resident had connected and started his own noon feeding without an assessment of the feeding tube placement or a water flush before starting it.</li> <li>*She agreed he might not have been getting the correct amount of water or Jevity solution ordered by the physician.</li> </ul> <p>Review of resident 9's intake and output record from 6/12/14 to the present date revealed:</p> <ul style="list-style-type: none"> <li>*Inconsistent charting of feeding tube water flushes as ordered by the physician.</li> <li>*Occasional documentation of 300 cc 12:00 p.m. (noon) feeding tube fluid, but rare documentation of sixteen hour overnight feeding (from 5:00 p.m. to 9:00 a.m.) fluid which would have been 1,360 cc with the present physician orders.</li> <li>*No documentation of output had been kept.</li> </ul> <p>Review of resident 9's November 2014 care plan entry for nutrition, hydration, and feeding tube revealed:</p> <ul style="list-style-type: none"> <li>*No information on the resident starting, changing rate, and stopping his own feeding solution administration.</li> <li>*No direction to have kept track of the resident's intake and output.</li> </ul> <p>Interview on 9/10/14 at 1:40 p.m. with the director of nursing (DON) revealed she:</p> <ul style="list-style-type: none"> <li>*Was unaware resident 9 had been connecting, starting, adjusting the rate of flow, and stopping</li> </ul>	F 279		

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F 279	<p>Continued From page 57</p> <p>his feeding tube and nutritional fluid that had been administered through a feeding pump.</p> <p>*Agreed the ordered feeding tube placement assessments and water flushes were not being completed when the resident self-administered (did himself) his feeding solution.</p> <p>*Agreed there was no way to accurately account for the amount of feeding solution resident 9 received since he was stopping and starting the feeding pump at will.</p> <p>*Agreed times for water flushes on the medication administration record had not been set to coincide with feeding times as ordered.</p> <p>*Agreed the care plan had not addressed the need to measure intake and output and was not updated regarding the resident's own adjustment of his feeding tube administration.</p> <p>The provider's 10/5/12 Enteral Nutrition/hydration policy and procedure revealed:</p> <p>*Prior to administering nutrition or hydration through a feeding tube there should have been an assessment and a check of the feeding tube placement.</p> <p>*Tubing should have been flushed with water before and after the feedings as ordered by the physician.</p> <p>*Intake and output were to have been recorded every shift while on the feeding tube.</p> <p>Surveyor: 32335</p> <p>11. Review of resident 5's medical record revealed the provider had not updated her care plan to address weight loss and being at risk for weight loss.</p> <p>Refer to F325, finding B.</p> <p>Further review of resident 5's undated care plan revealed:</p> <p>*She had a problem area regarding falls with the</p>	F 279			

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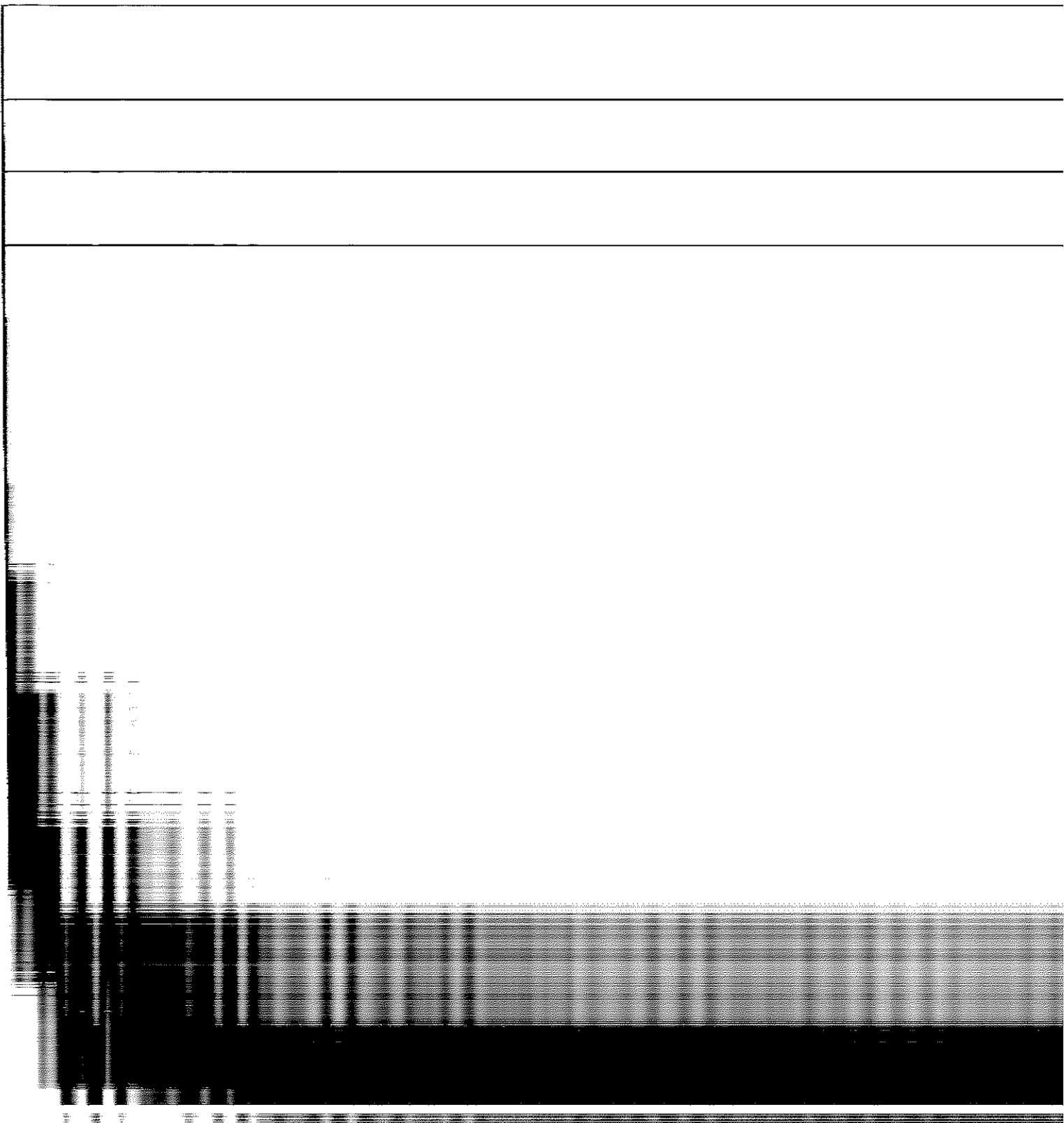
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F 279	<p>Continued From page 58 following intervention: -"Hi-lo bed with mat at bedside. Bed in low position when occupied. If my bed is in low position and I am found on the mat, it will not be counted as a fall but rather an intentional change in position."</p> <p>Interview on 9/10/14 at 7:50 a.m. with CNA S regarding resident 5 revealed the care plan was incorrect. That intervention had been used on a different resident who constantly would sit on the floor. She was unaware of how that intervention would have gotten onto resident 5's care plan.</p> <p>12. Review of resident 7's medical record revealed: *A form from the surgical center stated the suprapubic catheter (a tube into the bladder through a small hole in the belly and drains urine) placement surgery was scheduled for 8/27/14. *An interdisciplinary note dated 8/27/14 stated "OOF [out of facility] with daughter to Veteran's Administration Hospital (VA) for S/P [suprapubic] placement."</p> <p>Review of resident 7's undated care plan revealed it had not been updated to reflect the suprapubic catheter. Surveyor: 22452</p> <p>13. Review of the provider's 6/5/14 Comprehensive Care Plans policy revealed: *"An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident." **Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and:</p>	F 279			

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F 279	Continued From page 59 -Are resident oriented. -Are behaviorally stated. -Are measurable. -Contain timetables to meet the resident's needs."	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed 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: 32332 Based on record review, interview, and policy review, the provider failed to develop a comprehensive care plan to have included three of eight identified Care Area Assessments (CAA), (nutritional status, cognitive loss/dementia, and behavioral symptoms ) within seven days of the	F 280	1. The care plan was updated for Resident 30. Review of the clinical record determined there was no negative outcome related to the lack of care planning. The care plans for all residents with a comprehensive MDS in the last 90 days were reviewed against the CAA documentation to verify the development of an applicable care plan and updated as needed. 2. MDS Case Managers were educated about the CAAs and care planning process. One MDS Case Manager was designated as the coordinator of the MDS and care planning process. 3. The MDS Case Managers will randomly audit one of each other's care plans after completing a comprehensive MDS every week on an ongoing basis. The MDS Coordinator will report monthly at	10/10/14	



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F 280	<p>Continued From page 60</p> <p>comprehensive assessment for one of one sampled resident (30). Findings include:</p> <p>1. Review of resident 30's 8/19/14 CAAs revealed:</p> <ul style="list-style-type: none"> <li>*The comprehensive Minimum Data Set (MDS) had an assessment reference date (ARD) of 8/14/14.</li> <li>*Nutrition had been identified as an area of concern due to a therapeutic diet.</li> <li>*Cognitive loss/dementia had been identified as an area of concern.</li> <li>*Behavioral symptoms had been identified as an area of concern.</li> <li>*The CAA had indicated the team would have proceeded to the care plan to address the above concerns.</li> </ul> <p>Review of the 8/19/14 care plan revealed nutrition, cognitive loss/dementia, and behavioral symptoms had not been addressed.</p> <p>Interview on 9/10/14 at 8:10 a.m. with the provider's consultant dietitian revealed:</p> <ul style="list-style-type: none"> <li>*She had not addressed CAA findings in the care plan.</li> <li>*The resident should have had a nutritional care plan.</li> </ul> <p>Interview on 9/10/14 at 10:50 a.m. with the Warren wing Minimum Data Set coordinator QQ revealed:</p> <ul style="list-style-type: none"> <li>*Social services was to have addressed the cognitive loss/dementia and behavioral symptom areas on the care plan.</li> <li>*The social worker had just handed her the care plan on 9/10/14.</li> <li>*The care plan should have been developed within seven days of the comprehensive ARD that</li> </ul>	F 280	<p>the QAPI meeting on effectiveness of the MDS and care planning process. Based on report, further education and/or corrective action will be planned and carried out. These reports will occur until the QAPI committee determines otherwise.</p>		

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F 280	Continued From page 61 had been done on 8/14/14.  Review of the provider's 6/5/14 Comprehensive Care Plans policy revealed: *"The comprehensive care plan was based on a thorough assessment that included the MDS." **"Areas on concern that were triggered [identified] during the resident assessment were evaluated using the CAAs before interventions were added to the care plan." ***"The comprehensive care plan was to be developed within seven days of the completion of the resident's comprehensive assessment [for the MDS]."	F 280			
F 281 SS=H	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to: *Follow physician's orders for a urinalysis (obtain a urine specimen) for one of one sampled resident (1). *Administer medications according to the physicians' orders for four of four sampled residents (12, 16, 37, and 47). *Advocate the medical needs and administer the prescribed treatment in a timely manner for one of one sampled resident (3) after an emergency room evaluation. *Clarify post-hospital orders with the physician for two of two sampled residents (7 and 12).	F 281	1. Clinical records were reviewed for Residents 1, 3, 7, 9, 12, 13, 14, 15, 16, 31, 37 and 47 to identify the nurses who received the physician orders and should have carried out those order, and the care plans and CNA care cards were reviewed and updated. The staff involved were identified and counseled by the Director of Nursing. The Director of Nursing had a conversation with the pharmacy supplier to clarify the process for filling medication orders. All residents could be at risk for failure to carry out physician orders.	10/10/14	

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F 281	<p>Continued From page 62</p> <p>*Follow physician's orders for one of one sampled resident (13) who was administered Risperdal (an antipsychotic medication).</p> <p>*Weights were consistently obtained and documented for one of one sampled resident (15) who was on dialysis (artificial means of removing toxins from the body).</p> <p>*Follow physicians' orders for weight monitoring for one of two sampled residents (14) who were on enteral (tube in the stomach) feedings.</p> <p>*Obtain a physician's order for the use of side rails for one of one sampled resident (9).</p> <p>*Document a skin assessment for one of one sampled resident (31) who had an order for DuoDerm (topical patch for pressure ulcers). Findings include:</p> <p>1. Review of resident 1's 9/2/14 through 9/9/14 interdisciplinary progress notes revealed: *9/2/14 at 10:15 a.m. "Denies nausea-is pale and lethargic [sleepy]. No emesis [vomiting] since 8/28/14. Poor appetite. Pale in color." *9/2/14 at 5:15 p.m. "White blood count 16.0 [normal less than 11.0 and elevated is indicative of an infectious process]. Unknown etiology [cause]." *9/2/14 at 5:40 p.m. - "Get urinalysis. Start intravenous [IV] 200 cubic centimeters (cc) at 200 cc per hour for 1000 cc. See in clinic on 9/3/14."</p> <p>Further review of 9/3/14 through 9/9/14 notes revealed no documentation a urinalysis had been obtained.</p> <p>Interview on 9/8/14 at 11:00 a.m. with registered nurse (RN) MM regarding resident 1 revealed: *She had transcribed the physician's order on 9/2/14 for the urinalysis. She had passed it on in report to obtain the urinalysis the next morning.</p>	F 281	<p>2. A. Ongoing education will be developed for licensed staff regarding professional standards of practice related to nursing processes.</p> <p>B. All new physician orders received the day before will be reported during the daily (M-F) clinical stand-up meeting with the interdisciplinary team (IDT). Following the IDT, the MDS Case Managers will randomly audit the records for all of the residents affected by new physician orders to ensure the orders were carried out, and care plans/CNA care cards were updated, as needed. If any orders are identified as not carried out, the MDS Case Manager will report this to the Director of Nursing who will counsel the staff person involved and/or provide corrective education, as needed.</p> <p>C. Weekly weights will be completed at the time of bathing, the CNAs will report the weight to the licensed nurse who will document the weight on the Vitals</p>		

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F 281	<p>Continued From page 63</p> <p>Someone had written "Done" on their 24 hour communication sheet, so she thought it had been obtained.</p> <p>*On 9/6/14 the resident had told her she still did not feel well.</p> <p>*She realized on 9/6/14 the urinalysis had not been obtained, so she obtained an order from the physician to straight catheterize (tube directly into the bladder) the resident for the urine specimen.</p> <p>*She had sent the urine specimen to the laboratory on 9/6/14, and it had returned with abnormal results.</p> <p>*The physician was still waiting for the culture report before he ordered an antibiotic (medication for infection).</p> <p>2a. Review of resident 12's August 2014 medication administration record (MAR) revealed: *8/13/14- Venlafaxine (antidepressant medication) had not been given "Medication not here." *8/24/14- Senna Plus (stool softner) had not been given "Not given-no medication."</p> <p>b. Review of resident 16's September 2014 MAR revealed: *I-Vite (vitamin supplement) one twice a day (BID). *There was documentation all the doses had been administered.</p> <p>Observation on 9/10/14 at 10:45 a.m. of resident 16's bottle of I-Vite in the medication cart revealed: *There was documentation the bottle had been opened on 9/1/14 and contained sixty pills. *There were forty-nine pills left in the bottle. *There should have been forty-one pills in the bottle if the I-Vite had been administered 9/1/14</p>	F 281	<p>record. All nursing staff were educated on the weekly weight and documentation process, assignments, and completion of the weekly weight documentation.</p> <p>D. All side rails will be removed and replaced with transfer rails upon receipt; order was placed on 10/3/14.</p> <p>3. The Director of Nursing will report monthly, on a continuous basis, at the QAPI meeting on progress of professional standards being met and action plans will be developed for further education and/or correction.</p>		

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F 281	<p>Continued From page 64 at 8:00 a.m. through 9/10/14 at 8:00 a.m.</p> <p>c. Review of resident 37's August 2014 MAR revealed Calcitonin (nasal spray for osteoporosis) had not been administered on 8/1/14 and 8/2/14 "No medication."</p> <p>Observation 9/10/14 at 11:00 a.m. of resident 37's Calcitonin nasal spray revealed: *The bottle had an open date of 7/22/14. *The manufacturer's instructions on the label read "Bottle to not be used past 30 days."</p> <p>d. Review of resident 47's June 2014 through September 2014 MAR revealed: *I-Vite one tablet daily. *Vesicare (urine frequency medication) one tablet daily. *There was documentation both the I-Vite and Vesicare had been administered as ordered.</p> <p>Observation on 9/4/14 at 8:00 a.m. and on 9/10/14 at 11:15 of resident 47's bottles of I-Vite and Vesicare in the medication cart revealed: *There was documentation on the bottle of I-Vite it had been opened on 6/22/14 and contained sixty pills. *There was six I-Vite pills left in the bottle on 9/10/14. *There should have been 80 I-Vite tablets administered since 6/22/14 instead of 54 if it had been administered as ordered by the physician. *On 9/4/14 there was a bottle of Vesicare tablets with an opened date of 8/19/14 and four pills remained in the bottle. *Seventeen pills of Vesicare should have been administered from 8/19/14 through 9/4/14. There should have been thirteen pills of Vesicare in the bottle on 9/4/14 instead of four.</p>	F 281			

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F 281	<p>Continued From page 65</p> <p>e. Interview on 9/10/14 at 11:45 a.m. with the DON regarding the above residents' medication discrepancies revealed she: *Was unaware of the medications not being available from pharmacy. *Confirmed the bottles of medication did not reconcile with what had been documented as administered on the residents' MARs. Surveyor: 32332 3. Review of resident 31's medical record documentation regarding his coccyx revealed: *An 8/19/14 physician's order for DuoDerm (type of dressing) to be applied to "a red area on his bottom, at the top of the coccyx (tailbone) area." *The 8/15/14 through 9/2/14 Interdisciplinary Progress Notes indicated: -On 8/19/14 at 3:30 p.m. "New orders for DuoDerm to coccyx area Q [every] three days/PRN [as needed]." -On 9/2/14 at 1:15 a.m. "DuoDerm in place on bottom."  The Skin Assessment documentation form indicated: *On 8/14/14 at 10:55 p.m. skin was warm, dry, and intact. *On 8/21/14 at 11:20 p.m. "Skin warm/dry/intact. DuoDerm to coccyx for prevention of skin breakdown. See NPSCR [non-pressure skin condition report] for concerns." -On 8/29/14 at 12:35 a.m. "Skin W/D/I [warm, dry, intact]. DuoDerm to coccyx for prevention of skin breakdown. See NPSCR for concerns." *No documentation on 8/19/14 regarding the coccyx skin breakdown or orders for dressings. *No NPSCR form for the coccyx had been located in the medical record. *No documentation regarding skin measurements</p>	F 281		

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F 281	<p>Continued From page 66 or current status had been located in the medical record.</p> <p>Interview on 9/10/14 at 11:00 a.m. with the DON revealed: *Her expectation was the nurse assessing resident 31's skin would document skin measurements on the NPSCR form. *She had been unable to locate the NPSCR form in the chart, in the Warren wing skin assessment book, or in the medical records.</p> <p>Interview on 9/10/14 at 12:20 p.m. with MDS coordinator QQ regarding resident 31's skin concerns revealed: *Skin concerns were to have been documented on the Skin Assessment form. *His coccyx had not been initially documented on the Skin Assessment form. *His skin assessments were to have been routinely documented on the NPSCR sheet. *She had been unable to locate the NPSCR sheet in the chart or in the skin assessment book in the Warren wing nurses station. *There would have been no way of knowing how his skin had looked as he had been discharged on 9/2/14.</p> <p>Review of the provider's September 2011 Skin Assessments policy revealed: *The purpose was to monitor residents known to have a history of or be at risk of pressure ulcers or have skin breakdown. *Staff would perform skin assessments with measurements on a weekly basis. *The initial assessment and documentation of skin concerns/conditions were made on the Initial Skin Report by the staff nurse who identified the condition.</p>	F 281			

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F 281	<p>Continued From page 67</p> <p>*The form was then given to the nurse manager who placed it in the resident's medical record.</p> <p>**Non-pressure related skin breakdown issues are documented weekly on the non-pressure skin condition report by the staff nurse."</p> <p>*Staff nurses were to use the skin assessment notebook to be aware of which skin concerns to follow-up on.</p> <p>Surveyor: 33265</p> <p>4a. Observation on 9/3/14 from 5:15 p.m. through 5:30 p.m. of resident 9 revealed:</p> <p>*His feeding tube (tube going directly into ) was not connected and the feeding pump was not infusing at 5:15 p.m.</p> <p>*His feeding tube was connected and the feeding pump was infusing at 5:30 p.m.</p> <p>*No one had entered his room during that time frame.</p> <p>*Resident had history of connecting and disconnecting his own feeding tube to the feeding pump.</p> <p>Review of resident 9's complete medical record revealed:</p> <p>*An interdisciplinary progress note on 6/15/14 at 5:00 p.m. that described the resident adjusting the rate of his feeding on his tube feeding pump.</p> <p>-Rate had been at 186 cubic centimeters (cc) per hour instead of the 85 cc per hour ordered.</p> <p>*Physician's orders to:</p> <p>-Check feeding tube placement before each feeding was dated 8/13/12.</p> <p>-Give a 200 cc flush of water through the feeding tube before and after each feeding was dated 8/12/13.</p> <p>-Jevity (nutritional solution to go through feeding tube in place of meals) 1.0 was to have been infusing at 85 cc per hour for sixteen hours (5:00 p.m. to 9:00 a.m.) was dated 5/27/14.</p>	F 281			

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F 281	<p>Continued From page 68</p> <p>-Jevity 1.0 was to have been infusing at 200 cc per hour for one and a half hours each noon was dated 6/23/14.</p> <p>-A 200 cc flush of water was to be one through the feeding tube every four hours was dated 7/23/14.</p> <p>Interview on 9/3/14 at 5:37 p.m. with RN B revealed she:</p> <ul style="list-style-type: none"> <li>*Was aware resident 9 had been starting and stopping his tube feeding himself.</li> <li>*Agreed there was no date or time documented on the Jevity solution container.</li> <li>*Agreed he might not have been getting the correct amount of Jevity or fluids ordered by the physician.</li> <li>*Agreed the assessments and water flushes might not have been done as ordered by physician.</li> <li>*Was not sure the date or time the current container of feeding solution had been hung.</li> </ul> <p>Observation on 9/8/14 from 12:00 p.m. (noon) to 1:07 p.m. of resident 9 revealed:</p> <ul style="list-style-type: none"> <li>*At 12:00 p.m. (noon), 12:21 p.m., and 12:40 p.m., his feeding tube was not connected or infusing.</li> <li>*At 12:44 p.m. his visitor left. The feeding tube was not connected or infusing at that time.</li> <li>*At 12:53 p.m. the feeding tube was connected to the solution and infusing at 250 cc per hour instead of the physician's ordered 200 cc per hour.</li> <li>*No one had entered the room since the visitor left.</li> </ul> <p>Interview on 9/8/14 at 1:08 p.m. with RN A regarding resident 9's feeding tube orders revealed she:</p>	F 281			

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F 281	<p>Continued From page 69</p> <ul style="list-style-type: none"> <li>*Believed his next feeding was at 5:00 p.m.</li> <li>*Stated he needed his every four hour 200 cc water flush done and proceeded to the resident's room.</li> <li>*Identified the feeding tube was infusing at that time.</li> <li>*She stopped the feeding pump and disconnected the feeding tube to administer the water flush.</li> <li>*She reconnected the feeding tube.</li> <li>*She restarted the feeding pump.</li> <li>*She asked the resident if he had connected his feeding tube and started his feeding. The resident stated he had. When asked why he stated no one came at noon to start it.</li> <li>*She was aware that resident 9 had been starting and stopping his feeding himself.</li> <li>*She agreed the resident had connected and started his own noon feeding without an assessment of the feeding tube placement or a water flush before starting it.</li> <li>*She agreed he might not have been getting the correct amount of water or Jevity solution ordered by the physician.</li> </ul> <p>Review of resident 9's intake and output record from 6/12/14 to the present date revealed:</p> <ul style="list-style-type: none"> <li>*Inconsistent charting of feeding tube water flushes as ordered by the physician.</li> <li>*Occasional documentation of 300 cc 12:00 p.m. (noon) feeding tube fluid, but rare documentation of sixteen hour overnight feeding (from 5:00 p.m. to 9:00 a.m.) fluid which would have been 1,360 cc with the present physician orders.</li> <li>*No documentation of output had been kept.</li> </ul> <p>Interview on 9/10/14 at 1:40 p.m. with the director of nursing (DON) revealed she:</p> <ul style="list-style-type: none"> <li>*Was unaware resident 9 had been connecting,</li> </ul>	F 281			

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F 281	<p>Continued From page 70</p> <p>starting, adjusting the rate of flow, and stopping his feeding tube and nutritional fluid that had been administered through a feeding pump.</p> <p>*Agreed the ordered feeding tube placement assessments and water flushes were not being completed when the resident self-administered (did himself) his feeding solution.</p> <p>*Agreed there was no way to accurately account for the amount of feeding solution resident 9 received since he was stopping and starting the feeding pump at will.</p> <p>*Agreed times for water flushes on the medication administration record had not been set to coincide with feeding times as ordered.</p> <p>The provider's 10/5/12 Enteral Nutrition/hydration policy and procedure revealed:</p> <p>*Prior to administering nutrition or hydration through a feeding tube there should have been an assessment and a check of the feeding tube placement.</p> <p>*Tubing should have been flushed with water before and after the feedings as ordered by the physician.</p> <p>*Intake and output were to have been recorded every shift while on the feeding tube.</p> <p>4b. Observation on 9/2/14 at 6:00 p.m. in resident 9's room revealed two quarter bed rails in place on each side of the upper half of the resident's bed.</p> <p>Review of resident 9's complete medical record revealed:</p> <p>*The 6/3/14 care plan entry for activities of daily living and toileting identified one-half side rails for repositioning on the upper half of both sides of the bed.</p> <p>*A physician's order for "bed bars" (side rails) for</p>	F 281		

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F 281	<p>Continued From page 71</p> <p>repositioning was dated over two months later on 8/26/14.</p> <p>*There was no assessment on the use of the side rails in the medical record.</p> <p>5. Observation on 9/2/14 at 6:00 p.m. in resident 9's room revealed two quarter bed rails in place on each side of the upper half of the resident's bed.</p> <p>Review of resident 9's completed medical record revealed:</p> <p>*The 6/3/14 care plan entry for activities of daily living and toileting identified bilateral one-half side rails for repositioning.</p> <p>*A physician's order for bed bars in bed for repositioning was dated over two months later on 8/26/14.</p> <p>*There was no assessment on use of side rails in the medical record.</p> <p>Review of resident 15's complete medical record revealed:</p> <p>*She was on dialysis three days a week.</p> <p>*She had a physician's order for daily weights dated 2/3/11.</p> <p>-From 6/12/14 to 6/30/14 two daily weights were not documented.</p> <p>-July 2014 seven daily weights were missing.</p> <p>-The August 2014 daily weight sheet could not be located at the time of the survey.</p> <p>-On a weekly weight chart for August there had been only one entry instead of four.</p> <p>*There was inconsistent notation as to if the weights were taken before or after dialysis treatment.</p> <p>*The pocket care plan used by the certified nursing assistants (CNAs) dated 8/17/14 identified her as needing weekly weights instead</p>	F 281			

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F 281	<p>Continued From page 72 of daily weights as ordered by physician.</p> <p>Interview on 9/10/14 at 1:40 p.m. with the director of nursing revealed she agreed: *Weights should have been done daily as the physician ordered. *Weights should have included when they were done, as in before or after dialysis that could change weights. *There should have been a nursing assessment that included weights immediately before leaving for dialysis and upon return from dialysis.</p> <p>Review of the provider's 10/28/13 outpatient dialysis policy revealed: *A nursing assessment was to have been completed prior to being transported to outpatient dialysis and immediately after returning from dialysis. *The assessment was to have included vital signs and a weight prior to and after returning from dialysis. Surveyor: 32331 6. Review of resident 14's medical record revealed he: *Was admitted on 7/3/14. *Had been on a tube feeding since admission. *He had a physician's order on 7/3/14 for "Weight Weekly."</p> <p>Review of resident 14's weight sheet from the first week in July 2014 through the first week in September 2014 revealed *The weekly weights were not completed for: -July, weeks two and four. -August, weeks three and four.</p> <p>Interview on 9/9/14 at 10:35 a.m. with the consultant registered dietitian regarding resident</p>	F 281		

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F 281	<p>Continued From page 73</p> <p>14's weights revealed: *He had a physician's order for weekly weights. *Weekly weights had not been consistently obtained. *She would have expected the weights to have been obtained as ordered.</p> <p>Surveyor: 32332 Interview on 9/10/14 at 8:35 a.m. with certified nurse assistant (CNA) X revealed when asked how weights were to have been obtained stated: *Monthly weights were to have been obtained on all residents on the first seven days of each month. *Weekly weights were to have been obtained on Monday or Tuesday so they would have been available for staff meetings. *No one had been responsible for obtaining the weights, "Just whoever does it, does it." *The bath aide was never responsible for obtaining weights.</p> <p>Interview on 9/10/14 at 8:40 a.m. with nurse aide SS revealed: *The nurses had been primarily responsible for obtaining residents' weights. *If the nurses had been too busy the nurse aides would obtain them.</p> <p>Interview on 9/10/14 at 8:45 a.m. with RN EE and medication technician (med tech)/CNA TT revealed: *The CNA was responsible for obtaining resident weights. *Monthly weights were to have been obtained the first ten days of each month. *The nurses and med techs were not responsible for obtaining weights. *CNAs obtained weekly weights on Mondays.</p>	F 281			

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F 281	<p>Continued From page 74</p> <p>*There was no set time for obtaining the weights; the staff were to obtain the weights whenever they got the chance. It did not matter what time of day it had been done.</p> <p>Surveyor: 32331 Interview on 9/10/14 at 8:15 a.m. with the director of nursing regarding resident 14's weights revealed: *His weight had not been completed weekly. *She would have expected the weekly weights to have been obtained as physician ordered.</p> <p>Review of the provider's revised 12/11/12 Weight and Height policy revealed: *All new admissions would have had their weights taken weekly for one month. -Then monthly thereafter unless otherwise indicated, during the resident's stay. Surveyor: 33488 7. Review of resident 12's medical record revealed: *He had a history of diabetes and had been treated with Actos and Januvia (oral diabetes medications). *Those medications had been discontinued on August 28, 2014. *No documentation was made by staff or the primary care physician in reference to the above medication discontinuance.</p> <p>Interview on 9/9/14 at 4:30 p.m. with LPN AA regarding resident 12 revealed she: *Was unaware his above medications had been discontinued. *Was unsure if the physician's orders to discontinue the medications had been clarified by staff. *Then placed a call to the physician to clarify the</p>	F 281			

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F 281	<p>Continued From page 75</p> <p>above medication orders upon request by this surveyor.</p> <p>*Agreed there had been no supporting documentation or rationale by the physician with regards to the above medications.</p> <p>*Stated clarification by nursing staff should have been obtained and documented for the above medication orders.</p> <p>Interview on on 9/10/14 at 2:00 p.m. with registered nurse (RN) A regarding resident 12 revealed she:</p> <p>*Confirmed he had been admitted to the Veterans hospital on 9/1/14 and discharged back to the facility on 9/3/14 with orders to continue the above medications.</p> <p>*Had been unsure who had discontinued the medication on 8/28/14.</p> <p>*Stated she re-admitted the resident to the facility and had reviewed the orders from the hospital upon his return.</p> <p>*Was unaware the physician's orders stated the diabetes medication were to be continued.</p> <p>*Never clarified that section in the discharge summary.</p> <p>*Would only add new medications and therapies to a resident's medication or treatment record.</p> <p>*Agreed physicians' orders needed to be clarified with the primary physician and/or the discharging hospital if there had been discrepancies.</p> <p>*Stated "I should have called and clarified."</p> <p>*Agreed choosing what orders to follow instead of clarifying the orders had been out of her scope of practice as a nurse.</p> <p>8. Review of resident 13's medical record revealed:</p> <p>*There were physician's orders to increase her daily dose of Risperdal (a medication used to</p>	F 281			

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F 281	<p>Continued From page 76</p> <p>treat mood disorders) received from hospice and signed by the primary care provider on 7/16/14. *The order was noted (transcribed) by the nursing staff on 7/17/14. *The above medication dose change had not been implemented as ordered.</p> <p>Interview on 9/10/14 at 2:00 p.m. with RNA regarding resident 13 revealed she: *Had written a note on 7/21/14 that read "Found PO (physician's order) from hospice that had not been processed. Changed doses of Risperdal." *Agreed that had been a medication error. *Had not contacted the physician to notify him of the omission of the increased dose for five days, and she should have made him aware of it.</p> <p>Review of the provider's undated Discontinued Drugs/Medications policy revealed nursing staff must record the following information in the resident's medical record: *Date and time the medication had been discontinued. *Name and strength of the medication. *Name of the physician. *Disposition of remaining medication. *Signature and title of person recording the information. *Other as necessary or appropriate.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 358, revealed, "A registered nurse makes a telephone report when significant events or changes in a patient's condition have occurred."</p> <p>Review of Audrey Knippa et al., Fundamentals for Nursing, 7th Ed., October 2011, Safe Medication</p>	F 281		

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F 281	<p>Continued From page 77</p> <p>Administration and Error Reduction, page 488, revealed:</p> <ul style="list-style-type: none"> <li>*Question the provider if the prescription is unclear.</li> <li>*Report all errors and implement corrective measures.</li> </ul> <p>Surveyor: 30170</p> <p>9. Observation and interview on 9/3/14 at 9:15 a.m. with resident 3 revealed:</p> <ul style="list-style-type: none"> <li>*He was unshaven and had dried greenish nasal drainage in his mustache.</li> <li>*The hair was quite long and unkempt. He looked as though he had not had a haircut for several months.</li> <li>*His scalp was reddened and had a large amount of dry scaling skin noted. The dry skin was layered and thick on his scalp.</li> <li>*Both ears were very pink, had scabbed areas on the lobes of the ears, and were scaling and dry.</li> <li>*The back of his neck was quite pink and had dry scaly skin.</li> <li>*He was hard of hearing.</li> <li>*He stated his scalp, ears, and neck were "itchy."</li> <li>*He was uncertain as to how long he had that scaling and dryness to those areas.</li> </ul> <p>Interview on 9/3/14 at 10:20 a.m. with registered nurse (RN) B regarding resident 3's skin issues revealed:</p> <ul style="list-style-type: none"> <li>*She stated "He is a mess."</li> <li>*He had the skin issues to the scalp, neck, and ears since 7/10/14.</li> <li>*His primary physician had seen him, and there was a dermatology appointment made for September 16 through the Veteran's Administration (VA).</li> <li>*There had been no treatment ordered after the skin issues had been identified.</li> </ul>	F 281		

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F 281	<p>Continued From page 78</p> <p>*She was unsure as to the reason there had been no treatments attempted prior to his dermatology appointment.</p> <p>Telephone interview on 9/3/14 at 10:30 a.m. with VA Community Care coordinator G and RN H from the VA regarding resident 3 revealed: *He had a dermatology appointment scheduled for September 16 via telemedicine. *He had been seen on 7/3/13 at the VA. The provider called the VA on 7/11/14 and then that was when the dermatology appointment had been scheduled. *They both were unsure as to the reason there had been no medical treatment provided for resident 3's skin condition.</p> <p>Interview on 9/3/14 at 11:00 a.m. with MDS (Minimum Data Set) coordinator E regarding resident 3 revealed: *There had been no treatment provided for the resident's scalp that she had been aware of . *She was responsible for his MDS. *She would have gone by what the nurses charted, because she did not perform skin assessments on her residents. She only did pain assessments.</p> <p>Interview on 9/3/14 at 3:40 p.m. with RN B regarding resident 3 revealed: *There had been no medical intervention for his scalp, neck, and ears skin issues. *The VA had been contacted on 7/10/14.</p> <p>Review of resident 3's 2/14/14 individualized care plan revealed there had been no documentation that he had scalp, ear, and neck skin issues. There was no documentation regarding any scheduled appointments, or that a physician had</p>	F 281		

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F 281	<p>Continued From page 79</p> <p>been notified about his skin issues that had started on 7/10/14.</p> <p>Interview and observation on 9/3/14 at 3:50 p.m. with the director of nursing (DON) in resident 3's room revealed:</p> <ul style="list-style-type: none"> <li>*She was unaware of his skin issues.</li> <li>*She agreed the skin issues were severe.</li> <li>*She agreed there should have been some medical treatment intervention from the primary physician or the VA prior to his dermatology appointment on September 16, 2014.</li> </ul> <p>Review and interview on 9/8/14 at 11:30 a.m. of resident 3's September treatment administration record (TAR) with RN A revealed:</p> <ul style="list-style-type: none"> <li>*He had been seen on 9/4/14 at the emergency room.</li> <li>*He had an order for a new medication for his scalp.</li> <li>*The new medication order had not been placed on his current TAR.</li> <li>*RN A stated she had ordered the medication from the pharmacy on 9/4/14.</li> <li>*She had not noted the new physician's order for the ketoconazole shampoo and had not transcribed the new physician's order on to resident 3's September 2014 TAR.</li> <li>*The new medication was found in the top drawer of the medication cart unopened.</li> <li>*He had not received the medicated shampoo that had been physician ordered four days ago.</li> <li>*She agreed the medicated shampoo ordered on 9/4/14 should have been started immediately.</li> <li>*She confirmed she had not appropriately transcribed the physician's order onto the TAR, and that had delayed resident 3 from obtaining his treatment for his scalp for four days.</li> </ul>	F 281		

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F 281	<p>Continued From page 80</p> <p>Interview on 9/8/14 at 11:45 a.m. with the DON regarding the above concerns regarding resident 3 revealed:</p> <p>*The physician's orders should have been transcribed onto the September TAR after the order had been received. That would have ensured timely treatment for his scalp.</p> <p>*She confirmed the delay in the transcription of the physician's orders caused the resident unnecessary discomfort.</p> <p>*The treatment should have been started on 9/4/14.</p> <p>Review of resident 3's September 2014 TAR on 9/8/14 at 3:30 p.m. revealed the physician's order from 9/4/14 had been transcribed by RN A on 9/8/14 four days after the order had been received.</p> <p>Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing 8th Ed., St. Louis, Mo., 2013, p. 4, pp. 6 and 7, and p. 305 , revealed:</p> <p>*"The Standards of Practice describe a competent level of nursing care. The levels of care are demonstrated by the critical thinking model known as the nursing process, assessment, diagnosis, outcomes identification, and planning, implementation, and evaluation. The nursing process is the foundation of clinical decision making and includes all significant actions by nurses in providing care to patients."</p> <p>*"As a nurse, you are responsible for obtaining and maintaining specific knowledge and skills for a variety of professional roles and responsibilities. Nurses provide care and comfort for patients in all health care settings. Nurse's concerns for meeting the patient's needs remains the same whether care focuses on health promotion and</p>	F 281		

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F 281	<p>Continued From page 81</p> <p>illness prevention, disease and symptom management. Accountability means that you are responsible, professionally and legally, for the type and quality of nursing care provided." *The healthcare provider (physician or the advanced practice nurse) was responsible for directing medical treatment. Nurses follow health care provider's orders unless they believed the orders were in error or would harm patients (residents). Surveyor: 32335 10. Review of resident 7's medical record revealed: *A form from the surgical center stated the suprapubic catheter (a tube into the bladder through a small hole in the belly which drains urine) placement surgery was scheduled for 8/27/14. *An interdisciplinary note dated 8/27/14 stated "OOF [out of facility] with daughter to VA for S/P [suprapubic] placement." *A patient instructions sheet for wound/incision care that was not signed and not dated. *There were no specific instructions on the patient instruction sheet regarding catheter care. *There was no documentation staff had contacted the primary physician for orders to care for the suprapubic catheter.</p> <p>Review of resident 7's September 2014 treatment administration records revealed no order for changing the suprapubic catheter dressing.</p> <p>Observation on 9/9/14 at 11:05 a.m. by surveyor 30170 of RN A completing suprapubic catheter care revealed the dressing had been dated and initialed on 8/31/14. The dressing had not been changed for nine days. RN A stated the expectation would have been to change the</p>	F 281		

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F 281	<p>Continued From page 82 dressing daily.</p> <p>Interview on 9/9/14 at 11:15 a.m. with primary physician I regarding resident 7 revealed: *He had not been informed of the suprapubic catheter placement done on 8/27/14. *He had just learned of the suprapubic catheter placement during the interview with this surveyor. *The resident was a VA patient, but he was still his primary care physician. *He would have expected the dressing to be changed daily. *The staff never tell him what was going on with residents under his care.</p> <p>Interview on 9/9/14 at 3:15 p.m. with the administrator and the DON revealed: *The DON stated she would have to check their policy on catheter care to determine if going nine days without a dressing change had been okay. *At the time of the survey exit the DON had still not provided a response or policy relevant to the above discussion.</p> <p>Interview on 9/10/14 at 10:25 a.m. with RN EE revealed the provider did not have standing orders for catheter care.</p> <p>Review of the provider's 5/15/13 Dressings, Dry/Clean policy revealed staff were to verify there was a physician's order for the procedure.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 305, revealed: *Nurses should follow health care providers' orders unless they believe the orders are in error. *If the nurse found an error further clarification from the health care provider should have been</p>	F 281			

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F 281	Continued From page 83 obtained.	F 281			
F 309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30170 A. Based on observation, interview, record review, and policy review, the provider failed to ensure an appropriate nursing assessment, monitoring, care planning, and medical treatment intervention for one of sampled resident (3) who had significant redness, scaling, and itching of the skin on his scalp, neck, and ears for two months. Findings include:</p> <p>1. Observation and interview on 9/3/14 at 9:15 a.m. with resident 3 revealed: *He was unshaven and had dried greenish nasal drainage in his mustache. *He looked as though he had not had a haircut for several months. His hair was quite long and unkept. *His scalp was reddened and had a large amount of dry scaling skin noted. The dry skin was layered and thick on his scalp. *Both ears were very pink, had scabbed areas on the lobes of the ears, and were scaling and dry. *The back of his neck was quite pink and had dry</p>	F 309	<p>1. Observation of Resident 3 and review of his clinical record determined the scalp condition is improving with no further negative outcome; the care plan and CNA care cards were reviewed and revised, as needed. Resident 17 passed away on 8/22/14. Clinical records for all residents with skin conditions, pain management, and/or end of life care to ensure appropriate nursing assessment, monitoring, care planning, and medical treatment interventions were documented. The care plans for residents receiving hospice services were reviewed to ensure the facility and hospice care plans were collaborative.</p> <p>2. All new physician orders received the day before will be reported during the daily (M-F) clinical stand-up meeting with the interdisciplinary team (IDT). Following the IDT, the MDS Case Managers will randomly audit the</p>	10/10/14	

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F 309	<p>Continued From page 84</p> <p>scaly skin. *He was hard of hearing. *He stated his scalp, ears, and neck were "itchy." *He was uncertain as to how long he had that scaling and dryness to those areas.</p> <p>Interview on 9/3/14 at 10:05 a.m. with certified nursing assistant (CNA) C regarding resident 3 revealed: *She had only been employed one week with the provider. *He would not let her comb his hair, because he stated, "it hurt" when she attempted to comb his hair. *She was unsure how long it had been since he had been shaved or given a bath. *She and CNA D had notified the nurse's about his skin issues on his scalp, ears, and neck.</p> <p>Interview on 9/3/14 at 10:10 a.m. with CNA D regarding resident 3 revealed: *His shower day was Thursday, and he refused to take a shower at times. *He would complain of pain in his scalp when she attempted to comb it. *She had talked to the nurses about his scalp pain.</p> <p>Interview on 9/3/14 at 10:20 a.m. with registered nurse (RN) B regarding resident 3's skin issues revealed: *She stated "He is a mess." *He has had the skin issues to the scalp, neck, and ears since 7/10/14. *His primary physician had seen him, and there was a dermatology appointment made for September 16 through the Veteran's Administration. *There had been no treatment ordered after the</p>	F 309	<p>records for all residents affected by new physician orders to ensure the orders were carried out, and care plans/CNA care cards were updated, as needed. If any orders are identified as not carried, the MDS Case Manager will report this to the Director of Nursing who will counsel the staff person involved and/or provide corrective education, as needed.</p> <p>3. The Director of Nursing will report monthly, on a continuous basis, at the QAPI meeting on progress of standards being met and action plans will be developed for further education and/or correction.</p>	

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F 309	<p>Continued From page 85</p> <p>skin issues had been identified.</p> <p>*She was unsure as to the reason there had been no treatments attempted prior to his dermatology appointment.</p> <p>Telephone interview on 9/3/14 at 10:30 a.m. with VA community care coordinator G and RN H regarding resident 3 revealed:</p> <p>*He had a dermatology appointment scheduled for September 16 via telemedicine.</p> <p>*He had been seen on 7/3/13 at the VA. The provider called the VA on 7/11/14 and then that was when the dermatology appointment had been scheduled.</p> <p>*They both were unsure as to the reason there had been no medical treatment provided for resident 3's skin condition.</p> <p>Interview on 9/3/14 at 11:00 a.m. with MDS (Minimum Data Set) coordinator E regarding resident 3 revealed:</p> <p>*There had been no treatment provided for the residents scalp that she was aware of .</p> <p>*She was responsible for his MDS.</p> <p>*She would have gone by what the nurses charted, because she does not perform skin assessments on her residents. She only does pain assessments.</p> <p>Interview on 9/3/14 at 11:15 p.m. with licensed social worker F regarding resident 3's skin concerns revealed:</p> <p>*He was typically unshaven. That's who he was.</p> <p>*He had refused care at times.</p> <p>*She was unaware that his scalp, neck, and ears were that bad.</p> <p>*She would have expected the nurses to intervene for his skin condition.</p> <p>*She agreed the primary care physician should</p>	F 309			

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F 309	<p>Continued From page 86</p> <p>have been involved with the immediate care of his scalp.</p> <p>Observation on 9/3/14 at 12:25 p.m. of resident 3 at the Center dining room table revealed as he was eating his noon meal he kept scratching his scalp, ears and face. He only at approximately 10 percent of his noon meal. Then got up from the table and left the dining room.</p> <p>Interview on 9/3/14 at 3:40 p.m. with RN B regarding resident 3 revealed: *There had been no medical intervention for his skin issues on his scalp, neck, and ears. *The VA had been contacted on 7/10/14.</p> <p>Review of resident 3's 2/14/14 individualized care plan revealed there had been no documentation that he had scalp, ear, and neck skin issues. There was no documentation regarding any scheduled appointments, or that a physician had been notified about his skin issues that had started on 7/10/14.</p> <p>Interview and observation on 9/3/14 at 3:50 p.m. of resident 3's scalp, neck, and ears with the director of nursing (DON) in resident 3's room revealed: *She was unaware of his skin issues. *She agreed the skin issues were severe. *She agreed there should have been some medical treatment intervention from the primary physician or the VA prior to his dermatology appointment on September 16, 2014.</p> <p>Telephone interview on 9/3/14 at 4:55 p.m. with primary care physician I regarding resident 3 revealed he: *Had not felt that the residents skin condition was</p>	F 309			

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F 309	<p>Continued From page 87</p> <p>an emergency.</p> <p>*Stated, "I don't know what to do with him."</p> <p>*Had the skin condition for a few months.</p> <p>*Felt the resident was "lucky" to have had an appointment with the VA dermatology.</p> <p>Interview and observation on 9/4/14 at 9:45 a.m. with the medical director in resident 3's room regarding his skin issue, revealed:</p> <p>*He was unaware the skin issue was acute. He thought it looked like a chronic condition.</p> <p>*He agreed the skin condition should have had medical treatment intervention by the primary physician before the scheduled dermatology appointment.</p> <p>Observation on 9/4/14 at 11:30 a.m. of resident 3 in the Center dining room revealed he had been sitting at the dining room table. Intermittently he was scratching his scalp and ears.</p> <p>Review of resident 3's interdisciplinary progress notes revealed:</p> <p>*On 9/3/14 at 4:00 p.m. "Writer called Res. (resident) family if it would be okay with Res. going to a provider outside the VA to be seen regarding skin/scalp issues. Fam (family) okay with this, PCP (primary care physician) does not think he needs to be seen ASAP (as soon as possible) and can wait to be seen at the VA 9/16 - clinic need the PCP to call and refer him in the clinic in order to be seen tomorrow, PCP doesn't not think this is necessary and will not refer him."</p> <p>*On 9/4/14 at 10:00 a.m. "Medical Director examined scalp; believes he needs to be seen today at VA ER (emergency room). Notified PCP and he gave order."</p> <p>*On 9/4/14 at 1:15 p.m. "Res. went to VA ER via (by) w/c [wheelchair] Express."</p>	F 309		

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F 309	<p>Continued From page 88</p> <p>*On 9/4/14 at 3:50 p.m. "Res. has new order for Ketoconazole shampoo twice weekly. Also to keep derm (dermatology) appt (appointment) later this month."</p> <p>Review of resident 3's 8/26/14 physician's progress notes revealed there had been no documentation of his scalp, ears, and neck skin issues by the primary care physician.</p> <p>Review of resident 3's 9/4/14 summary after the ER visit revealed: **"Needs to be seen for scalp problem per medical director." **"Seborrheic Dermatitis [similar to eczema/dandruff, affects the scalp, may also be known as "cradle cap", itchy and inflamed skin]. Rx [prescription] ketoconazole 2% [percent] shampoo relieved flaking, scaling, and itching associated with seborrheic dermatitis topically twice weekly. Need to keep the dermatology appt scheduled for 16 Sept (September) 2014."</p> <p>Observation on 9/8/14 at 11:00 a.m. of resident 3 revealed: *He continued to have reddened, scaling, and flaking skin on his scalp. *His ears were dry and had scabbed areas. *His neck continued to be quite pink in color. *He appeared unkept, his hair was long and uncombed. *Facial hair was long and uneven.</p> <p>Interview on 9/8/14 at 11:15 a.m. with CNA K regarding resident 3 revealed: *She had not given the resident a bath. *She knew of no new treatment for his scalp. *If there was a new order for a special shampoo the nurses would have communicated that to her.</p>	F 309			

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F 309	<p>Continued From page 89</p> <p>*The new treatment would have been placed on her bathing schedule, so she would have known to use the new shampoo when bathing him.</p> <p>Review and interview on 9/8/14 at 11:30 a.m. of resident 3's September treatment administration record (TAR) with RN A revealed:</p> <p>*He had been seen on 9/4/14 at the ER.</p> <p>*He had a physician's order for a new medication for his scalp.</p> <p>*The new medication order had not been placed on his current TAR.</p> <p>*RN A stated she had ordered the medication from the pharmacy on 9/4/14.</p> <p>*She had not noted the new physician's order for the ketoconazole shampoo and had not transcribed the new physician's order onto his September 2014 TAR.</p> <p>*The new medication was found in the top drawer of the medication cart unopened.</p> <p>*He had not received the medicated shampoo that had been physician ordered four days ago.</p> <p>*She agreed the medicated shampoo ordered on 9/4/14 should have been started immediately.</p> <p>*She confirmed she had not appropriately transcribed the physician's order onto the TAR, and that had delayed him from obtaining his treatment for his scalp for four days.</p> <p>Interview on 9/8/14 at 11:45 a.m. with the DON regarding the above concerns regarding resident 3 revealed:</p> <p>*The physician's orders should have been transcribed onto the September TAR after the order had been received. That would have ensured timely treatment for his scalp.</p> <p>*She confirmed the delay in the transcription of the physician's orders caused the resident unnecessary discomfort.</p>	F 309		

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F 309	<p>Continued From page 90</p> <p>*The treatment should have been started on 9/4/14.</p> <p>Review of resident 3's September 2014 TAR on 9/8/14 at 3:30 p.m. revealed the order had been transcribed by RN A. The resident had received the physician's ordered medicated shampoo for his scalp.</p> <p>Review of resident 3's 2/14/14 individualized care plan indicated there had been no revision to his plan of care to include his current medicated shampoo treatment twice weekly that had been ordered on 9/4/14.</p> <p>Observation on 9/9/14 at 10:00 a.m. of resident 3 ambulating in the hallway revealed: *His hair had been trimmed. *He facial hairs had been shaved. *His scalp was less scaly and less reddened. *His ears appeared less scaly. *He was smiling. His appearance was much improved.</p> <p>Review of the provider's 11/8/12 Guidelines for Nursing Documentation policy revealed: *All observations, medications, and treatments given, services performed, actions taken would have been documented in an accurate, detailed, and readable manner in order to have provided an accurate and detailed description of the condition of the resident.</p> <p>Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing 8th Ed., St. Louis, Mo., 2013, p. 4, pp. 6 and 7, and p. 305 , revealed: *"The Standards of Practice describe a competent level of nursing care. The levels of</p>	F 309		

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F 309	<p>Continued From page 91</p> <p>care are demonstrated by the critical thinking model known as the nursing process, assessment, diagnosis, outcomes identification, and planning, implementation, and evaluation. The nursing process is the foundation of clinical decision making and includes all significant actions by nurses in providing care to patients."</p> <p>**As a nurse, you are responsible for obtaining and maintaining specific knowledge and skills for a variety of professional roles and responsibilities. Nurses provide care and comfort for patients in all health care settings. Nurse's concerns for meeting the patient's needs remains the same whether care focuses on health promotion and illness prevention, disease and symptom management. Accountability means that you are responsible, professionally and legally, for the type and quality of nursing care provided."</p> <p>*The healthcare provider (physician or the advanced practice nurse) is responsible for directing medical treatment. Nurses follow health care provider's orders unless they believe the orders are in error or harm patients.</p> <p>Surveyor: 22452</p> <p>B. Based on record review, interview, and policy review, the provider failed to assess, monitor, and document pain management and end-of-life care for one of one sampled hospice (terminally ill) resident (17). Findings include:</p> <p>1. Review of resident 17's medical record revealed:</p> <p>*An 8/7/14 admission date from an acute care hospital.</p> <p>*Diagnosis of malignant neoplasm (tumor) of the lung.</p> <p>*He expired (passed away) on 8/22/14.</p>	F 309		

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NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105</b>		
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F 309	<p>Continued From page 92</p> <p>Review of resident 17's 8/7/14 physician's orders revealed: *Hydrocodone (narcotic pain medication) 5/325 milligrams (mg) one tablet every six hours as needed for pain. (That was discontinued on 8/7/14 by the physician and, then resumed on 8/12/14). *Acetaminophen 500 mg, two tablets every four hours as needed for mild pain.</p> <p>Review of resident 17's 8/21/14 physician's orders revealed: **Patient declining, reporting difficulty swallowing, less responsive, and transitioning toward actively dying." **"Okay to discontinue all scheduled medications." **Roxanol (narcotic pain medication) 0.25 milliliter (ml) to 1.0 ml every one hour as needed (PRN) for shortness of breath (SOB) or pain." **Lorazepam (antianxiety medication) 1.0 mg one tablet crushed and given buccally (inside side of mouth) every one hour PRN anxiety/restlessness."</p> <p>Review of resident 17's 8/8/14 through 8/22/14 PRN medication record revealed: *Pain monitoring 0 to 10 with 0 being no pain and 10 being worst possible pain. *Non-pharmacological interventions to include: -Food/fluids. -Books on tape. -Toileting. -Massage. -Repositioning. -Soft music. -Quiet environment. -Aromatherapy. -Spiritual counseling.</p>	F 309			

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F 309	<p>Continued From page 93</p> <ul style="list-style-type: none"> <li>-Deep breathing.</li> <li>-Reassurance.</li> <li>-Exercise.</li> <li>-Relaxation.</li> <li>-Dim lighting.</li> <li>-Warm compress.</li> <li>-Cold compress.</li> </ul> <p>*Acetaminophen had been documented as administered eight times from 8/8/14 through 8/18/14.</p> <p>*Five doses of the acetaminophen had no location for the pain.</p> <p>*Acetaminophen had been documented as administered on 8/8/14 with no location of pain at a pain rating of 8. Food/fluids, repositioning, relaxation, and dim lighting had been documented as non-pharmacological interventions. There was no follow-up documentation to the effectiveness of the acetaminophen or non-pharmacological interventions.</p> <p>*Acetaminophen had been documented as administered on 8/15/14 for chest pain at a pain rating of 6 with no non-pharmacological interventions documented. There was no follow-up documentation to the effectiveness of the acetaminophen.</p> <p>*Acetaminophen had been documented as administered on 8/18/14 with no location of pain, no pain rating, and no non-pharmacological interventions documented.</p> <p>*There was no non-pharmacological interventions documented for the acetaminophen administered on 8/9/14, 8/12/14, 8/13/14, and 8/15/14.</p> <p>*There was no documentation of any pain medication administration after 8/18/14.</p> <p>*The resident never received any hydrocodone, Roxanol, or lorazepam.</p>	F 309		

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F 309	<p>Continued From page 94</p> <p>Review of resident 17's 8/18/14 through 8/22/14 interdisciplinary progress notes revealed:</p> <p>*8/18/14 at 11:50 a.m. by hospice registered nurse (RN)- "Denies pain during visit. States he is comfortable."</p> <p>*8/21/14 at 5:00 p.m.- "Orders received to discontinue all scheduled medications/PRN medications. New order for Roxanol and lorazepam. Pharmacy made aware by hospice."</p> <p>*8/22/14, "Transferred to room 300 approximately at 9:00 a.m. Summoned to room at 9:55 a.m. No perceivable pulse or blood pressure. Family at bedside. Hospice nurse here at 10:00 a.m. Orders of doctor at 10:08 a.m."</p> <p>*There was no documentation from 8/18/14 through 8/22/14 of his pain control or his condition.</p> <p>Interview on 9/10/14 at 10:00 a.m. with the director of nursing regarding resident 17 revealed:</p> <p>*She had only been at the facility less than three weeks.</p> <p>*She was not going to state what her expectations of PRN follow-up should have been, as the nurses did not know yet what her expectations were.</p> <p>*He was moved to another room an hour before his death by orders of the administrator. The administrator felt since there was such a large number of visitors a larger room would be more appropriate.</p> <p>*When questioned by the surveyor the lack of documentation regarding his condition from 8/18/14 through 8/22/14 her response was "What would you expect?"</p> <p>Review of the provider's 1/20/12 Hospice Program policy revealed:</p>	F 309		

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F 309	Continued From page 95 **"When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency, and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms." **"Provision of drugs and medical supplies as needed for palliation (comfort) and management of the terminal illness and related conditions that will be provided by each entity."	F 309			
F 314 SS=H	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Appropriate repositioning, interventions, and care planning for three of four sampled residents (6, 12 and 13) who had current pressure ulcers. *Sufficient fluid intake for two of four sampled residents (12 and 13) who had a current pressure ulcers. Findings include:  1. Observations of resident 13 at various times throughout the day from 9/8/14 through 9/10/14	F 314	1. Clinical records for Residents 6, 12 and 13 were reviewed to ensure the care plans were updated and observations of care for those residents were conducted to ensure repositioning occurred. The clinical records for all residents who are identified as having a pressure ulcer were reviewed to ensure care plans and CNA care cards are accurate related to pressure ulcer interventions. All other residents who have moderate or high risk for pressure ulcer development according to their Braden score will be reviewed for appropriate interventions and accurate care planning to include repositioning schedules, hydration	10/10/14	

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F 314	<p>Continued From page 96 revealed:</p> <p>*On 9/8/14 from 11:25 a.m. until 12:45 p.m. she sat in her wheelchair.</p> <p>*During that time she was in the dining room being fed by staff.</p> <p>*Staff then took her to her room and transferred her to the commode (portable toilet) for toileting. Upon request by this surveyor, staff measured her pressure ulcer which was located just below her coccyx (tailbone area) on the inside of her left buttock.</p> <p>*She had a Stage II (shallow open area of skin) pressure ulcer measuring 2.5 centimeters (cm) by 2.4 cm at that time, along with two unstageable (depth was unmeasurable) pressure ulcers on both heels.</p> <p>*Her left heel ulcer measured 2.5 cm by 1 cm.</p> <p>*Her right heel ulcer measured 2.5 cm squared.</p> <p>*Staff moved her from her wheelchair to a sitting position in her recliner in her room.</p> <p>*She remained seated in that same position from 12:45 p.m. until 5:00 p.m.</p> <p>*She was then moved back into her wheelchair by staff and taken down for her supper meal.</p> <p>*She had remained in her wheelchair until this surveyor's last observation of her for the day at 6:30 p.m.</p> <p>*She remained seated and was not repositioned for a total of seven hours that day.</p> <p>*On 9/9/14 she was observed seated in her wheelchair in the dining room at 9:45 a.m. where she was fed by staff.</p> <p>*After breakfast, she was moved from the dining room to the nurse's station where she remained seated in her wheelchair.</p> <p>*This surveyor's last observation of her on 9/9/14 was at 4:00 p.m.</p> <p>*She remained upright in a chair without having been repositioned for a total of five hours that</p>	F 314	<p>program. Based on report, further education and/or corrective action will be planned and carried out and nutrition to be completed within the next 90 days.</p> <p>2. All nursing staff will be re-educated on pressure ulcer prevention, care planning, and treatment, including contributing factors such as hydration, nutrition, and repositioning. A certified wound care nurse will be hired within the next 60 days. A weekly Wound and Weight committee was started to include the MDS Case Managers, Director of Nursing, the certified wound care nurse, and the consultant Registered Dietitian to review all residents at risk for weight loss and/or wound management needs.</p> <p>3. At monthly QAPI meetings, the certified wound care nurse will provide a report, on a continuous basis, on pressure ulcer incidence and effectiveness of current treatments and prevention</p>		

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F 314	<p>Continued From page 97 day.</p> <p>*On 9/10/14 at 8:05 the resident was observed seated in her wheelchair in the dining room waiting for breakfast.</p> <p>*At 9:45 a.m. and again at 10:30 a.m. that same day her position in the wheelchair was observed to have been unchanged.</p> <p>Review of the medical record for resident 13 revealed:</p> <p>*She had a diagnosis of worsening dementia and had been admitted to hospice for her mental decline in April 2014.</p> <p>*The provider's current care plan dated 5/3/14 revealed:</p> <p>- "I can feed myself after you set up my food. Encourage me to lie and rest if I appear tired." The resident required staff to feed her and position her at the time of the survey.</p> <p>- "I am occasionally incontinent of bladder and am always continent of my bowels."</p> <p>*She was incontinent of both bowel and bladder at the time of this survey.</p> <p>- House supplements were added every meal on 8/1/14 "due to pressure ulcer."</p> <p>- Under the dehydration section it had been documented "I have a history of urinary tract infections. Encourage me to drink fluids when I am sitting up and awake."</p> <p>*She was dependent on staff for hydration (fluid intake) at the time of the survey and she had a recent urinary tract infection (UTI).</p> <p>*Her care plan had not been updated to reflect her needs or current level of care. It had not been combined with the hospice care plan.</p> <p>*The hospice care plan updated on 8/19/14 revealed:</p> <p>- She was incontinent of bowel and bladder as noted by the staff on 5/2/14.</p>	F 314		

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F 314	<p>Continued From page 98</p> <ul style="list-style-type: none"> <li>-On 6/3/14 she was to have begun wearing heel protectors at all times related to heel pressure ulcers.</li> <li>-On 6/19/14, she needed total assistance by staff with all care.</li> <li>-On 7/23/14 she was moved to the assisted feeding table, as she was unable to feed herself independently.</li> <li>*The hospice care plan had not been updated to meet all of her current needs.</li> <li>*The current undated pocket care plan used by the nursing assistants in providing care to residents revealed:             <ul style="list-style-type: none"> <li>-She was a known "hydration risk" but interventions had not been listed as how to care for her in regards to her hydration needs.</li> <li>-She was to be repositioned every two hours in bed.</li> <li>-There was no documentation to notify staff the resident was dependent on them for her nutrition and hydration.</li> <li>-The pressure ulcer on her coccyx was not listed under the skin care/pressure ulcer area. Staff would not have been able to know how to care for that area.</li> <li>-"Pillow boots in bed." That was not updated to remind staff her heel boots needed to be on at all times or that both of her heels had pressure ulcers.</li> </ul> </li> <li>*She required 30 milliliters (ml) of fluid per kilogram of body weight (71 kg) based off her base weight in July (before her weight loss) that totaled 2,154 ml of fluid per day to maintain hydration. Fluid records documented from 8/31/14 through 9/9/14 revealed she had received on average 810 ml of fluid daily. That was less than half of her needed hydration.</li> <li>*The latest Minimum Data Set (MDS) assessment dated 9/1/14 done monthly by</li> </ul>	F 314		

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F 314	<p>Continued From page 99</p> <p>nursing staff revealed:</p> <ul style="list-style-type: none"> <li>-Her nutritional status documented was "no change" for weight loss.</li> <li>-The skin condition section had no areas of concern or treatments listed.</li> <li>-The bowel and bladder section had been documented as "always incontinent."</li> <li>*The records of weights documented in her chart had been: <ul style="list-style-type: none"> <li>-158 pounds (lb) in July 2014.</li> <li>-153 lb in August 2014</li> <li>-145 lb on September 1, 2014</li> </ul> </li> <li>-Her re-weight a few days later had been 143 lb.</li> <li>*Her total weight loss in two months was 15 lb.</li> <li>*On 7/23/14 at the beginning of her weight loss, staff documented the resident had been moved to the assisted feeding table, as she was unable to feed herself independently.</li> <li>*Her Braden Scale (an assessment to predict risk for skin breakdown) had a score of 12. A score of 12 or less indicated she was at high risk for developing a pressure ulcer.</li> </ul> <p>Interview on 9/9/14 at 2:45 p.m. with nursing assistant (NA) JJ regarding residents on the east wing where resident 13 resided revealed:</p> <ul style="list-style-type: none"> <li>*She was unsure when or if any of the residents of the east wing needed to be repositioned or why.</li> <li>*She stated she had never documented any repositioning.</li> <li>*She had been unaware resident 13 had pressure ulcers.</li> <li>*She had been employed "about a month and a half" and was not a certified nurse aide yet.</li> <li>*She stated they were "short-staffed and residents were lucky to get good care."</li> <li>*She was placed on a weight restriction for muscle strain from lifting residents at the time of</li> </ul>	F 314			

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F 314	<p>Continued From page 100</p> <p>the survey from lack of additional staff to help. *She was "lucky to have another aide working on the wing today." *Stated resident 13 was dependent on staff for fluid and nutrition. *She was unsure how she and the other CNA would be able to transfer residents requiring an assist of two safely or at all if she was unable to lift (with her 5 lb. weight restriction). *Average time to answer a call light on the east wing she estimated, had been twenty minutes at best. *Residents were not always given care at the time the call light was answered, but would be routinely be told someone would be there shortly to help and the light was then shut off. *Commonly residents had to push their light "multiple times" before their needs were taken care of. That had occurred regularly since she had been employed at the facility.</p> <p>2. Observations on 9/9/14 at various times throughout the day of resident 12 revealed: *He had been in the dining room at 11:15 a.m. seated in his wheelchair. *His position in his wheelchair remained unchanged until 4:00 p.m. later that day when staff laid the resident in bed, so his ulcer could be measured. *Staff measured his Stage II pressure ulcer on his left buttock crease at 2 cm by 1 cm.</p> <p>Observation on 9/10/14 at 10:10 a.m. of resident 12's pressure ulcer revealed: *The pressure ulcer had increased in size from 9/9/14 measuring 2 cm squared. *Surrounding it had been a new area of reddened/purplish colored skin measuring an additional 2 cm to equal a 4 cm sized area in total</p>	F 314			

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F 314	<p>Continued From page 101 (that was confirmed by RNA).</p> <p>*There was another new area just below the original pressure ulcer, dark purple in color, unstageable, and it had measured 2.5 cm square.</p> <p>Review of the medical record for resident 12 revealed:</p> <p>*He had diagnoses of dementia, diabetes, a recent hip fracture prior to admission, and peripheral vascular disease (decreased blood flow to the extremities).</p> <p>*He was taking furosemide (a medication used to decrease water in the body to lower blood pressure.)</p> <p>*His current care plan dated 7/28/14 revealed he:</p> <ul style="list-style-type: none"> <li>-Required extensive assistance of one to two staff for all his care.</li> <li>-Frequently was incontinent (loss of control) of bladder and always incontinent of bowel.</li> <li>-Would need encouragement for fluids and was at risk for dehydration.</li> <li>-Was diagnosed with impaired skin integrity with excoriation (very reddened skin).</li> <li>-The ulcer was located on his coccyx on 8/12/14.</li> </ul> <p>*His Braden Scale had a score of 13 that placed him at moderate risk for a pressure ulcer.</p> <p>*He required 30 milliliters (ml) of fluid per kilogram of body weight (90 kg) based off his weight of 199 lb noted on his 9/1/14 admission to the Veterans Hospital. That weight required 2,713 ml of fluid per day to maintain his hydration.</p> <p>* Fluid records documented from 9/4/14 through 9/9/14 revealed he had received on average 1,183 ml of fluid per day, that was less than half of his needed hydration.</p> <p>*He had a recent UTI.</p> <p>*The latest Minimum Data Set (MDS) assessment dated 9/4/14 done monthly by nursing staff revealed:</p>	F 314			

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F 314	<p>Continued From page 102</p> <ul style="list-style-type: none"> <li>-No pressure ulcers had been documented on the skin condition section.</li> <li>-Turning and repositioning was not checked, although he had been check-marked in the "Other" section for positioning every two hours.</li> <li>*The current undated pocket care plan used by the nursing assistants in providing care to residents revealed:             <ul style="list-style-type: none"> <li>-The skin care/pressure ulcer section was blank.</li> <li>-It had not addressed repositioning.</li> <li>-It had not listed him as a hydration risk.</li> </ul> </li> </ul> <p>3. Interview on 9/10/14 at 2:00 p.m. with RN A regarding resident 12 revealed she:</p> <ul style="list-style-type: none"> <li>*Agreed the provider's and the hospice care plans were not updated or specific for staff to know how to care for residents.</li> <li>*Stated staff had not been repositioning residents by schedule or according to their current needs.</li> <li>*Stated she had not performed any new interventions for resident 12 since the new unstageable pressure ulcers had been found that morning. "I just don't have time."</li> <li>*Agreed without specific and measurable interventions, pressure ulcers would form or become worse.</li> <li>*Stated "His (resident 12) [pressure ulcer] will be worse by tomorrow I'm sure. We just don't have the staff or the time."</li> <li>*Stated residents who were dependent on staff for hydration had not been getting fluids between meals as staffing was poor.</li> <li>*Stated bedtime snacks were routinely not given or residents were often sleeping when staff had been offering them. That had been related to the lack of staff available.</li> <li>*Agreed more staff were needed in the facility and had been for a "very long time."</li> <li>*Stated she was doing her best but felt she "had</li> </ul>	F 314		

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F 314	<p>Continued From page 103 no time." *Stated the monthly MDS assessments had not been getting filled out correctly as nursing staff had little extra time being short staffed. They had been completing them often "without looking at the residents."</p> <p>Review of the provider's undated Prevention of Decubitus (Pressure) Ulcer policy revealed staff should have assisted compromised residents to reposition every two hours and to have encouraged them to drink plenty of fluids.</p> <p>Review of the provider's September 2011 Skin Assessment policy revealed: *The wound team would assess and provide interventions to assist in wound healing. *If the wound was not responding to treatment after two weeks an alternate intervention would have been put in place.</p> <p>Review of the provider's 8/11/09 Hydration Policy and Procedure policy revealed: *All residents would be offered a minimum of 1500 cc (same measurement as a ml) of fluid per day. *Nursing staff would assist residents who needed help.</p> <p>Review of the provider's 4/3/13 Standards of Care for _____(provider's name) policy revealed: *Nurse to notify MD (medical doctor)/Family/Dietician when skin concerns were present. *Turn and reposition residents every one and one-half to two hours and as needed.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, Chapter</p>	F 314		

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F 314	<p>Continued From page 104</p> <p>48-Skin integrity and Wound Care, pages 1176-1229, revealed:</p> <p>*"Nurses constantly observe for skin integrity and identify at-risk patients from developing pressure sores. Nursing interventions focus on prevention."</p> <p>*"Nurses understand factors affecting pressure ulcer formation and wound healing."</p> <p>*"Nurses apply the WOCN (wound, ostomy, and continence nurse) standards for prevention of pressure sores and assessment for skin integrity, prevention and treatment."</p> <p>Review of Madeleine Flanagan's Wound Healing and Skin Integrity- Principles and Practice 1st Ed., Hoboken, NJ, 2013, pages 122-131, revealed:</p> <p>*Risk factors for pressure ulcers are:</p> <ul style="list-style-type: none"> <li>-Age over 65</li> <li>-Chronic illness</li> <li>-Immobility</li> <li>-Mental impairment</li> <li>-Poor nutrition and dehydration.</li> <li>-Weight extremes (too little or too much).</li> </ul> <p>*"Frequency of repositioning is entirely dependent upon the individual's tissue tolerance. If conditions worsen or fail to improve frequency of repositioning must be more often."</p> <p>*"Continued repositioning is required even in the presence of pressure reducing devices."</p> <p>Surveyor: 32331</p> <p>4. Observation and interview on 9/3/14 at 9:40 a.m. with resident 6 in his room revealed:</p> <p>*He stated his physician had told him he had needed to lay down in the afternoon.</p> <p>*He was sitting in his room in his wheelchair (w/c).</p> <p>*He stated he slept in his bed, not in his recliner.</p> <p>*His bed was not always made by the afternoon</p>	F 314		

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F 314	<p>Continued From page 105 each day, so he had not been consistently laying down.</p> <p>Review of resident 6's medical record revealed: *He was admitted on 2/1/14. *He had diagnoses that had included dementia (a mental change in the thinking process), osteoarthritis (a disease of the joints), and weakness. *He had needed extensive assistance from two staff members for bed mobility, transfers, dressing, and toileting. *A physician's order on 5/8/14 "Up in Chair 1 1/2 hours every AM &amp; PM Otherwise Bedrest for Healing."</p> <p>Review of resident 6's July 2014 care plan revealed: **"I have a pressure ulcer on my coccyx [tailbone] due to my decreased mobility [movement from one place to another] and incontinence [unable to hold urine]." **"I want my pressure ulcer to be healed by our next meeting." **"Do treatment as ordered." **"Heel boots (new) bilaterally [both sides]." **"Sacral [located at the bottom of the spine] wound open." **"Please reposition me every couple of hours in w/c [wheelchair] or recliner to avoid prolonged pressure to any of my areas." **"I am unsteady and weak, and I need assistance transferring." **"I recently slid out of my recliner." **"I sleep in my recliner." *There was no documentation in his care plan regarding the physician's order for: -Up in chair for one and one-half hours every a.m. and p.m.</p>	F 314		

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F 314	<p>Continued From page 106</p> <p>-Otherwise bedrest for healing.</p> <p>*There was documentation in two different areas in his care plan that he slept in his recliner.</p> <p>Interview on 9/4/14 at 8:05 a.m. with CNA Y and CNA BB regarding resident 6 revealed:</p> <p>*He had not been sleeping in his recliner.</p> <p>*Both stated they had never observed him in his recliner.</p> <p>Review of resident 6's 7/25/14 Braden Scale (an assessment used for predicting pressure ulcer risk) revealed:</p> <p>*He had scored 13 on the assessment (a score of 12 or less indicated a high risk).</p> <p>*A score of 13 was at moderate risk for pressure ulcers.</p> <p>Review of resident 6's 7/28/14 Interdisciplinary Progress Notes by registered nurse (RN) J revealed he:</p> <p>*Was at moderate risk for pressure ulcers.</p> <p>*Had a stage II (partial thickness loss of skin presenting as a shallow open ulcer with a red or pink wound bed) pressure ulcer to his right heel and coccyx.</p> <p>*Had an unstageable (full thickness tissue loss in which the base of the ulcer is covered by dead tissue) pressure ulcer on his left heel.</p> <p>*Had pressure ulcer dressing changes.</p> <p>*Had a pressure reducing mattress on his bed at all times.</p> <p>*Had a seat cushion in his wheelchair (w/c).</p> <p>*Was occasionally incontinent of bladder.</p> <p>*Needed extensive assistance from two staff members for bed mobility, transferring, dressing, and toileting.</p> <p>Review of resident 6's 7/22/14 Minimum Data Set</p>	F 314		

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F 314	<p>Continued From page 107 (MDS) assessment revealed: *He required extensive assistance with bed mobility, transfer, dressing, toileting, personal hygiene, and bathing. *He was occasionally incontinent of urine. *He was at risk for developing pressure ulcers. *There was no documentation he had been placed on a turning/repositioning program.</p> <p>Observation on 9/8/14 at 2:30 p.m. of resident 6 in his room revealed he was sitting in his w/c in front of his TV.</p> <p>Interview on 9/9/14 at 9:30 a.m. with resident 6 in his room revealed he: *Was sitting up in his w/c. *Usually did not lay down in the a.m. *Had not thought he had enough time between breakfast and the noon meal to lay down. *Preferred to have laid down in the p.m., as he thought he had more time to do that. *Laid down "quite a bit more in the afternoon." *Complained that "hardly anybody comes down my hall to help me." *Stated he had not always gotten laid down in the p.m. as he had preferred.</p> <p>Interview on 9/9/14 at 9:55 a.m. with CNA VV and CNA WW regarding resident 6 revealed: *They were unaware he needed to be laid down in the a.m. and in the p.m. *That information was not available on their pocket care plan for that hall. *The Pocket Care Plan for east wing was used by the CNAs to guide their care for the residents.</p> <p>Review and interview on 9/9/14 at the same time and location with CNA VV regarding resident 6 and the undated Pocket Care Plan east wing</p>	F 314		

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F 314	<p>Continued From page 108 information revealed: *There was no information regarding him needing to have been laid down in the a.m. and the p.m. *The only information under skin care/pressure ulcer was: -"Float Heels/boots." *There was no information listed under the comments/special instructions column of the care plan.</p> <p>Interview on 9/9/14 at 10:00 a.m. with resident 6's physician I and another surveyor regarding resident 6 revealed: *The order for him to have been laid down in the a.m. and the p.m. came from another physician. *He thought that order had come from the wound center. *He would have liked to have seen him laid down to assist with his healing. *He needed to get that area healed. *He stated "he had healed up once, got worse again."</p> <p>Interview on 9/9/14 at 3:22 p.m. with licensed practical nurse (LPN) AA regarding resident 6 revealed: *He had not always laid down as his physician ordered. *That order was to have helped him heal his skin. *He had not always been agreeable to laying down in the a.m. and in the p.m. *It needed to have been "written down in his record" if he had refused to lay down. *She had not been aware of any communication to the physician who ordered the bedrest that he was not always compliant (cooperative and in agreement). *She agreed the physician should have been contacted regarding that.</p>	F 314			

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F 314	<p>Continued From page 109</p> <p>Review on 9/9/14 of resident 6's treatment administration record (TAR) for 9/1/14 through 9/9/14 revealed:</p> <p>*The physician's order for "Up in Chair 1 1/2 hours every AM &amp; PM Otherwise Bedrest for Healing."</p> <p>*Under AM on the TAR were:</p> <ul style="list-style-type: none"> <li>-Six days with nursing staff initials that he had been laid down.</li> <li>-One day was left blank.</li> <li>-Two days on 9/8/14 and on 9/9/14 the initials were circled with notes on the back of the TAR he had refused.</li> </ul> <p>*There were no other times that it had been written down he had refused.</p> <p>*Under PM on the TAR were:</p> <ul style="list-style-type: none"> <li>-Eight days with nursing staff initials that he had been laid down.</li> <li>-One day on 9/9/14 the initials were circled with a note on the back of the TAR he had refused.</li> </ul> <p>*There were no other times that it had been written down he had refused.</p> <p>Review of resident 6's August 2014 Daily Pressure Ulcer Monitoring Day sheet revealed:</p> <p>*He had three ulcer locations that were being monitored on the following areas:</p> <ul style="list-style-type: none"> <li>-Coccyx.</li> <li>-Right heel.</li> <li>-Left heel.</li> </ul> <p>Review of resident 6's Outpatient Wound Healing Center-Provider Orders Treatment Plans revealed he had gone to the wound center on 6/19/14 and 7/31/14.</p> <p>Interview on 9/9/14 at 4:00 p.m. with NA JJ regarding resident 6 revealed:</p>	F 314			

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F 314	<p>Continued From page 110</p> <p>*He seldom laid down in his bed in the a.m. after breakfast.</p> <p>*If he was going to lay down it was in the p.m. after lunch.</p> <p>*He always refused to lay down in his bed on afternoons when BINGO was being held.</p> <p>*BINGO had been held that day from 2:00 p.m. through 3:00 p.m.</p> <p>Observation on 9/9/14 at 4:00 p.m. of resident 6 in his room revealed he:</p> <p>*Was sitting in his w/c in front of his TV.</p> <p>*His head was down and his eyes were closed.</p> <p>Interviews on 9/9/14 at 12:10 p.m., 1:25 p.m., and at 4:45 p.m. with the director of nursing regarding resident 6 revealed:</p> <p>*He would refuse to lay down depending on the activities going on in the facility.</p> <p>*He would lay down and then want to get up after a few minutes.</p> <p>*She stated he was not always following his physician's bedrest order.</p> <p>*That should have been communicated with the physician that had ordered it.</p> <p>*She confirmed that order was not always being consistently followed by the nursing staff.</p> <p>*She confirmed that order had not been on his care plan.</p> <p>*She confirmed that information was also not on the Pocket Care Plan for East Hall used by the CNAs.</p> <p>Observation on 9/10/14 at 9:17 a.m. of resident 6 in his room revealed he was sitting in his w/c in front of his TV.</p> <p>Random observations of resident 6 in his room by this surveyor during the survey from 9/3/14</p>	F 314		

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F 314	Continued From page 111 through 9/10/14 revealed: *At no time had he been observed in his bed laying down in the a.m. or in the p.m. *When he was in his room he was sitting in his w/c in front of his TV.  Review of the provider's revised September 2014 Change in a Resident's Condition or Status policy revealed the purpose was to have had each resident's physician kept informed of changes in the resident's condition or status.  Review of the provider's revised August 2011 Skin Assessment policy revealed: *The purpose was to have monitored residents known to have a history of or be at risk of pressure ulcers. *All staff were to have been aware of a need to notify a nurse concerning any resident's skin concerns.	F 314			
F 322 SS=G	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS  Based on the comprehensive assessment of a resident, the facility must ensure that –  (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and  (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrh�ea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating	F 322	1. Observations and clinical record review for Residents 9 and 14 were conducted to ensure the feeding pump was working at the appropriate flow rate, the formula bag was dated, and weekly weights were conducted. The Registered Dietitian has set-up a schedule for Resident 9's tube feedings so that he will be able to participate in activities as desired. All other residents on tube feeding were changed to weekly weights	10/10/14	

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F 322	<p>Continued From page 112 skills.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, record review, and policy review, the provider failed to ensure routine assessment, monitoring, and documentation of tube feeding process for two of two residents (9 and 14) receiving tube feedings (gastric tube placed in the stomach for feedings and medication administration). Findings include:</p> <p>1. Observation on 9/3/14 from 5:15 p.m. through 5:30 p.m. of resident 9 revealed: *His feeding tube (tube going directly into ) was not connected and the feeding pump was not infusing at 5:15 p.m. *His feeding tube was connected and the feeding pump was infusing at 5:30 p.m. *No one had entered his room during that time frame. *Resident had history of connecting and disconnecting his own feeding tube to the feeding pump.</p> <p>Review of resident 9's complete medical record revealed: *An interdisciplinary progress note on 6/15/14 at 5:00 p.m. that described the resident adjusting the rate of his feeding on his tube feeding pump. *Physician's orders to: -Check feeding tube placement before each feeding was dated 8/13/12.</p>	F 322	<p>and other interventions were implemented.</p> <p>2. All licensed nurses will be re-educated by the consultant pharmacist on tube feeding policy and procedures, and will also be educated on adequate intake and output regarding residents who receive tube feeding.</p> <p>3. At monthly QAPI meeting, the Director of Nursing and the Registered Dietitian will provide a collaborative report, on a continuous basis, about effectiveness of the education on the tube feeding policy and procedures to ensure outcomes reflect an understanding and implementation of effective practices. Based on the report, further education and/or corrective action will be planned and carried out.</p>	

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105</b>		
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F 322	<p>Continued From page 113</p> <p>-Give a 200 cc (unit of measure) flush of water through the feeding tube before and after each feeding was dated 8/12/13.</p> <p>-Jevity (nutritional solution to go through feeding tube in place of meals) 1.0 was to have been infusing at 85 cc per hour for sixteen hours (5:00 p.m. to 9:00 a.m.) was dated 5/27/14.</p> <p>-Jevity 1.0 was to have been infusing at 200 cc per hour for one and a half hours each noon was dated 6/23/14.</p> <p>-A 200 cc flush of water was to be one through the feeding tube every four hours was dated 7/23/14.</p> <p>Interview on 9/3/14 at 5:37 p.m. with RN B revealed she:</p> <p>*Was aware resident 9 had been starting and stopping his tube feeding himself.</p> <p>*Agreed there was no date or time documented on the Jevity solution container.</p> <p>*Agreed he might not have been getting the correct amount of Jevity or fluids ordered by the physician.</p> <p>*Agreed the assessments and water flushes might not have been done as ordered by physician.</p> <p>*Was not sure the date or time the current container of feeding solution had been hung.</p> <p>Observation on 9/8/14 from 12:00 p.m. (noon) to 1:07 p.m. of resident 9 revealed:</p> <p>*At 12:00 p.m. (noon), 12:21 p.m., and 12:40 p.m., his feeding tube was not connected or infusing.</p> <p>*At 12:44 p.m. his visitor left. The feeding tube was not connected or infusing at that time.</p> <p>*At 12:53 p.m. the feeding tube was connected to the solution and infusing at 250 cc per hour instead of the physician's ordered 200 cc per</p>	F 322			

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F 322	<p>Continued From page 114</p> <p>hour.</p> <p>*No one had entered the room since the visitor left.</p> <p>Interview on 9/8/14 at 1:08 p.m. with RN A regarding resident 9's feeding tube orders revealed she:</p> <p>*Believed his next feeding was at 5:00 p.m.</p> <p>*Stated he needed his every four hour 200 cc water flush done and proceeded to the resident's room.</p> <p>*Identified the feeding tube was infusing at that time.</p> <p>*She stopped the feeding pump and disconnected the feeding tube to administer the water flush.</p> <p>*She reconnected the feeding tube.</p> <p>*She restarted the feeding pump.</p> <p>*She asked the resident if he had connected his feeding tube and started his feeding. The resident stated he had. When asked why he stated no one came at noon to start it.</p> <p>*She was aware that resident 9 had been starting and stopping his feeding himself.</p> <p>*She agreed the resident had connected and started his own noon feeding without an assessment of the feeding tube placement or a water flush before starting it.</p> <p>*She agreed he might not have been getting the correct amount of water or Jevity solution ordered by the physician.</p> <p>Review of resident 9's intake and output record from 6/12/14 to the present date revealed:</p> <p>*Inconsistent charting of feeding tube water flushes as ordered by the physician.</p> <p>*Occasional documentation of 300 cc 12:00 p.m. (noon) feeding tube fluid, but rare documentation of sixteen hour overnight feeding (from 5:00 p.m.</p>	F 322			

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F 322	<p>Continued From page 115 to 9:00 a.m.) fluid which would have been 1,360 cc with the present physician orders. *No documentation of output had been kept.</p> <p>Review of resident 9's medication administration record for September 2014 revealed: *The feeding tube fluid was to be infused twice a day from 5:00 p.m. to 9:00 a.m., and 12:00 p.m. (noon), to 1:30 p.m. *The water flushes before and after feedings were set for 4:00 a.m., 12:00 p.m.(noon), and 5:00 p.m. -The times should have been 12:00 p.m. (noon), 1:30 p.m., 5:00 p.m., and 9:00 a.m. *The every four hour water flush was set for 1:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m. (noon), and 5:00 p.m. -There should have been six times not five. -At these scheduled times the tube feeding was infusing or there was another order for the tube to be flushed. -There was no documentation on clarification of these doubled flush orders with the physician.</p> <p>Interview on 9/10/14 at 1:40 p.m. with the director of nursing (DON) revealed she: *Was unaware resident 9 had been connecting, starting, adjusting the rate of flow, and stopping his feeding tube and nutritional fluid that had been administered through a feeding pump. *Agreed the ordered feeding tube placement assessments and water flushes were not being completed when the resident self-administered (did himself) his feeding solution. *Agreed there was no way to accurately account for the amount of feeding solution resident 9 received since he was stopping and starting the feeding pump at will. *Agreed times for water flushes on the</p>	F 322			

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F 322	<p>Continued From page 116</p> <p>medication administration record had not been set to coincide with feeding times as ordered. *Agreed the care plan had not addressed the need to measure intake and output and was not updated regarding the resident's own adjustment of his feeding tube administration.</p> <p>The provider's 10/5/12 Enteral Nutrition/hydration policy and procedure revealed: *Prior to administering nutrition or hydration through a feeding tube there should have been an assessment and a check of the feeding tube placement. *Tubing should have been flushed with water before and after the feedings as ordered by the physician. *Intake and output were to have been recorded every shift while on the feeding tube. Surveyor: 22452 2. Review of resident 14's medical record revealed: *A 7/3/14 admission date. *He had a stomach tube for nutrition and medication. *He did not eat or drink anything by mouth.</p> <p>Review of resident 14's 7/3/14 physician's orders revealed "Jevity 1.2 at 80 cc/hr to be started daily at 5:00 a.m. and completed at 4:00 p.m."</p> <p>Observation on 9/3/14 at 11:00 a.m. of resident 14 revealed: *He was sitting in his room in his wheelchair. *A pump that was infusing his Jevity was beeping, and the Jevity had stopped infusing. *RN B adjusted the pump to stop the beeping, and the Jevity started to infuse again. *There was a 1000 cc container of Jevity hanging on the pump infusing that was marked with tape it</p>	F 322			

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F 322	<p>Continued From page 117</p> <p>had been started on 9/3/14 at 5:00 a.m. There was 750 cc of Jevity left in the container.</p> <p>Interview at that time with RN B regarding resident 14 revealed:</p> <ul style="list-style-type: none"> <li>*The pump used to infuse his Jevity had been stopping multiple times over the last few days.</li> <li>*She had changed pumps sometime last week, because the previous pump had also been stopping.</li> <li>*She had told administration three to four days ago of the problem with the pumps.</li> <li>*She confirmed when the pumps stopped he was not getting the complete 80 cc an hour.</li> <li>*It was undetermined how long the pump was off before someone heard them beeping and a nurse restarted the Jevity.</li> <li>*She agreed at this time if he had received the ordered Jevity 1.2 at 80 cc/hour since 5:00 a.m. there should have been 520 cc in the Jevity container instead of the 750 cc.</li> </ul> <p>Observation on 9/3/14 at 12:00 noon of resident 14 revealed:</p> <ul style="list-style-type: none"> <li>*He was sitting in his wheelchair in his room.</li> <li>*The pump was not beeping, and the Jevity was infusing at 80 cc/hour.</li> <li>*There was 700 cc of Jevity in the container. There should have been 440 cc Jevity left in the container according to the start time and infusion rate.</li> </ul> <p>Interview on 9/3/14 at 12:30 p.m. with the director of nursing regarding resident 14 revealed:</p> <ul style="list-style-type: none"> <li>*She confirmed the nursing staff had informed her a few days ago of the problem they were having with the feeding pumps.</li> <li>*They planned on ordering some new feeding pumps but had not done that yet.</li> </ul>	F 322			

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F 322	Continued From page 118 *She confirmed if the feeding pumps kept stopping he was not receiving the full amount of Jevity 80 cc/hour as ordered by the physician.  Interview on 9/3/14 at 12:40 p.m. with the administrator regarding resident 14 revealed: *He was not aware of the problem with the feeding pumps until now. *He would call and get more feeding pumps sent. *There were five feeding pumps in the storage room, and he was unsure if they were working correctly. One had a note taped to the outside of the pump that stated "broken" and one pump had a large amount of dried feeding solution on the outside of the pump. *He was not aware if the provider owned or rented the feeding pumps.	F 322		
F 323 SS=F	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: 33265 Based on observation, interview, record review, and policy review, the provider failed to ensure: *A system was in place to present unannounced or unknown entry into the facility from the outside entrance doors between the hours of 7:00 p.m. and 7:00 a.m.	F 323	1. A. Crash carts were checked and determined to have the necessary supplies and were locked. B. Observation of the key cards determined the programming functioned properly between the hours of 8:00 pm and 7:00 am. C. Review of the clinical record for Resident 15 determined she did not have any negative outcomes related to her visit to dialysis. Residents and family members/responsible parties	10/10/14

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F 323	<p>Continued From page 119</p> <p>*The crash cart in the center wing was easily and immediately accessible for emergency use.</p> <p>*Two of two crash carts were locked.</p> <p>*Two of two crash carts had documented daily checks for availability of required supplies and locking of the crash cart.</p> <p>*An accurate accounting of resident falls was being compiled and shared with the management staff.</p> <p>*There was a system to identify when a dialysis resident (15) left the facility for treatment and when they returned from treatment.</p> <p>*All registered nurses were trained on the correct use of cardiac defibrillators.</p> <p>Findings include:</p> <p>1. Observation on 9/5/14 at 9:00 p.m. revealed:</p> <p>*The sign on the front door informed visitors to press the button to use the intercom after 7:00 p.m.</p> <p>*After repeated pressing of the intercom button at the front entrance this surveyor was allowed into the building by an unknown employee inside the building.</p> <p>-This surveyor had spoken into the intercom but had heard nothing in response.</p> <p>*The intercom volume at the center wing was on the lowest setting possible At that setting nothing could have been heard at the front door or inside the builidnig at the intercom on center wing.</p> <p>Observation on 9/6/14 at 11:00 p.m. revealed this surveyor gained unannounced entrance to the facility by using the key card hanging outside the entrance door to the Warren (rehabilitation) wing.</p> <p>Observation on 9/7/14 at 10:00 a.m. revealed:</p> <p>*The entrance code for the outside door near the east wing dining room and nurses station was</p>	F 323	<p>will be informed of the process for signing in and out on or before 10/10/14.</p> <p>D. Review of the clinical records for Residents 33, 58, 59, 60, 61 and 64 revealed the care plans were updated with post-fall interventions and have not had injuries related to subsequent falls. The clinical records for all residents who have had a fall in the last 30 days were reviewed to ensure thorough investigation, care planning, and incident documentation occurred.</p> <p>2. A Risk Management committee was established to meeting monthly, with the Environmental Services Manager serving as the coordinator of Risk Management. A revised procedure for the crash carts was implemented and monitored weekly to ensure supplies are available and the carts are locked. All nursing staff will be re-educated on the signing out process when residents leave the building, on the Incident policy</p>		

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F 323	<p>Continued From page 120 written on the keypad on the outside entrance doorframe. *The code that had been written on the outside key pad allowed entrance into the facility.</p> <p>Observation on 9/7/14 at 8:45 p.m. revealed this surveyor gained entrance using the key card hanging outside of the Warren wing door.</p> <p>Interview on 9/10/14 at 1:40 p.m. with the director of nursing (DON) revealed she agreed the entrances needed to be secured at night for the safety of residents and employees.</p> <p>Surveyor 16385 Interview on 9/8/14 at 3:00 p.m. with the director of environmental services revealed entrance to the building was gained by entering a key pad code at some doors or by swiping an access card at four other exit doors. He stated the exit doors had been set to lock from 8:00 p.m. to 7:00 a.m.</p> <p>Interview on 9/9/14 at 8:10 a.m. with the administrator revealed four exit doors (Warren wing, East patio, East outside patio, and East rehab) had been equipped with an access card system to enter the building. He stated the access card was programmed to open the doors from 7:00 a.m. to 8:00 p.m. He and the receptionist had the ability to program the door access cards.</p> <p>Review of the October 2013 entry door policy and procedure revealed: "Doors will be equipped with any one or combination of the following security devices; Key Fob access with limited hours (7 am - 8 pm)."</p> <p>Surveyor 33265</p>	F 323	<p>and procedures and form, on the crash cart procedures, and on responding to use of the intercom at the front door. The Incident policy and procedure and incident form were revised. Incidents related to falls or injuries of unknown will be reviewed during daily (M-F) IDT stand-up meeting.</p> <p>3. At monthly QAPI meetings, the Risk Management Coordinator will provide a report, on a continuous basis, of preventive maintenance and equipment repairs, incidence of falls related to environmental conditions, and security of the facility. Based on report, further education and/or corrective action will be planned and carried out.</p>	

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F 323	<p>Continued From page 121</p> <p>2. Observation on 9/2/14 at 6:00 p.m. of the center wing clean utility room revealed three items were blocking access to the crash cart. Those items were an over-the-bed table, an oxygen concentrator, and a large closed cardboard box. The three items would have had to have been untangled and moved before access to the crash cart would have been possible.</p> <p>Observation on 9/9/14 at 9:45 a.m. revealed the crash cart on the center wing was blocked by an oxygen concentrator and an over-the-bed table.</p> <p>Interview on 9/10/14 at 1:40 p.m. with the director of nursing revealed she agreed the crash cart should be immediately accessible at all times.</p> <p>3. Observations on 9/2/14 at: *6:00 p.m. on the center wing in the clean utility room revealed the crash cart was not locked. *6:40 p.m. on the Warren wing in the oxygen storage room revealed the crash cart was in the locked position, but three of the drawers were able to be opened.</p> <p>Observation on 9/9/14 at: *9:45 a.m. revealed the crash cart on the center wing was not locked. *10:00 a.m. revealed the crash cart on the Warren wing was in the locked position, but three drawers were able to be opened.</p> <p>Interview on 9/10/14 at 1:40 p.m. with the director of nursing revealed she agreed the crash cart should be locked when not being used to ensure all items remained intact for emergency use.</p> <p>4. Review of the provider's Crash Cart Check list</p>	F 323		

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F 323	<p>Continued From page 122</p> <p>for June, July, August, and September 2014 revealed the cart was not documented as having been locked, having a key present to unlock, and supplies checked for the following:</p> <p>*Center wing crash cart: -June, fourteen of thirty days. -July, sixteen of thirty-one days. -August, fifteen of thirty-one days. -September, four of nine days.</p> <p>*Warren wing crash cart: -July, twenty-nine of thirty-one days. -August, twenty-eight of thirty-one days. -September, eight of nine days.</p> <p>Interview on 9/10/14 at 1:40 p.m. with the director of nursing revealed she agreed the crash cart should have been checked each night by night nursing staff.</p> <p>Review of the provider's undated night shift duties list revealed a crash cart check was required every night by night nursing staff.</p> <p>Review of the provider's 5/15/13 emergency medical equipment cart policy revealed that adequate supplies were to be available at all times.</p> <p>5. Review of the falls summary reports for June, July, and August 2014 and complete medical record review of six residents ( 33, 58, 59, 60, 61, and 64) listed on falls summary sheet revealed: *Resident 58 had one fall in June 2014 that had not been included on the falls summary form. *Resident 61 had one fall in June 2014 that had not been included on the falls summary form. *Resident 33 had one fall in July 2014 that had not been included on the falls summary form. *Resident 59 had one fall in July 2014 that had</p>	F 323		

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F 323	<p>Continued From page 123</p> <p>not been included on the falls summary form. *Resident 64 had one fall in July 2014 that had not been included on the falls summary form. *Resident 60 had three falls in August 2014, one of which had not been included on the falls summary form. She had been listed as a resident with two falls for that month.</p> <p>Interview on 9/5/14 at 10:50 a.m. with the administrator revealed there was no fall log kept, only monthly fall summary forms.</p> <p>Interview and fall record review on 9/10/14 at 11:30 a.m. with RN J revealed: *She had compiled the information for the falls summary form. *She was suppose to have received the first page of all post fall risk assessment forms. *She counted falls for each month and shared that with the management staff. *New resident falls were considered any resident who had been there less than thirty days who had fallen regardless of the month. *After review and comparison of the number of fall risk assessment forms in residents' medical records with what had been reported on the fall summary forms she revealed: -She worked with the fall risk assessment forms she received. There might have been ones she had not received. -She had not included on the falls summary form if a resident fell only once during any one month. She only included multiple falls as that was what had been done before. -She had a fall log on a computer program, and she tracked all fall risk assessment forms she had received.</p> <p>Interview on 9/10/14 at 1:40 p.m. with the director</p>	F 323		

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F 323	<p>Continued From page 124 of nursing (DON) revealed:</p> <ul style="list-style-type: none"> <li>*She had multiple fall risk assessment forms turned in to her that she believed were the originals.</li> <li>*She had believed copies of the entire fall risk assessment forms went to the Minimum Data Set coordinator who was to have been tracking falls.</li> <li>*She had not been aware the single falls during any one month were not included on the falls summary form.</li> </ul> <p>Review of the provider's 10/28/13 Falls Risk Assessment and Managing policy revealed the staff were to have looked for evidence of a possible link between:</p> <ul style="list-style-type: none"> <li>*The onset of falling.</li> <li>*An increase in falling.</li> <li>*Resent changes in the current medications.</li> </ul> <p>6. Interview on 9/9/14 at 11:00 a.m. with RN A revealed resident 15 had been going to dialysis between 1:00 p.m. and 1:30 p.m. Resident 15 had told RN A she thought she would be going earlier today. RN A had not known what time resident 15 was leaving for dialysis.</p> <p>Review of resident 15's medical record and sign out notebook at the center wing nurses station revealed no notation as to when resident 15 had left for dialysis.</p> <p>Interview on 9/9/14 at 2:20 p.m. with RN A revealed she was not aware when resident 15 left for dialysis.</p> <p>Interview on 9/10/14 at 1:40 p.m. with the director of nursing revealed she agreed the facility needed to know when residents left the facility and when they returned.</p>	F 323		

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F 323	Continued From page 125  Surveyor: 16385  Surveyor: 30170 3. Observation and interview on 9/2/14 at 7:10 p.m. with registered nurse KK in the Warren unit revealed: *A medical crash cart (used in emergency situations) was placed in the clean utility room. *There was a debrillator [AED (automatic external debrillator)] placed in the bottom drawer of the crash cart. *RN KK revealed he had no knowledge of checking the AED to have made sure it was ready to use in an emergency situation.	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: Surveyor: 32331 A. Based on observation, record review,	F 325	1.A. Observations and clinical record review for Residents 9 and 14 were conducted to ensure the feeding pump was working at the appropriate flow rate, the formula bag was dated, and weekly weights were conducted. The consultant Registered Dietitian has completed all assessments for nutritional intervention related to tube feeding. The Registered Dietitian has set-up a schedule for Resident 9's tube feedings so that he will be able to participate in activities as desired.	10/10/14	

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F 325	<p>Continued From page 126</p> <p>interview, and policy review, the provider failed to maintain adequate nutritional status for two of two sampled residents (9 and 14) on a tube feeding resulting in weight loss. Findings include:</p> <p>1. Observation on 9/3/14 at 5:05 p.m. of resident 14 in his room revealed: *A 1000 cc (cubic centimeter) ready-to-hang prefilled tube feeding container of Jevity 1.2 (a tube feeding nutrition supplement). *The Jevity 1.2 was infusing on the feeding pump at a flow rate of 80 cc per hour. *The pump digital reading read "183 ml [milliliters] fed." -That amount of tube feeding would have equaled 183 cc or 6 ounces (oz). *The resident was verbalizing he was "hungry" and "thirsty."</p> <p>Interview on 9/3/14 at 5:07 p.m. with licensed practical nurse UU regarding resident 14 revealed: *There had been "issues" with the feeding pump which had been currently beeping. *The physician had ordered his feeding to go until 6:00 p.m. that evening due to problems with the pump. *He complained about being hungry "a lot of the time." *With him "a common thing was thirst."</p> <p>Observation on 9/3/14 at 6:30 p.m. of resident 14 in his room revealed: *That same above container of the tube feeding. *The flow rate on the feeding pump was set at 80 cc per hour. *The feeding pump digital read "295 ml fed." -That amount of tube feeding would have equaled 295 cc or approximately 10 oz.</p>	F 325	<p>B. Clinical record review for Resident 5 determined the resident has been assessed by the Registered Dietitian and care plan and meal card were updated. All other residents on tube feeding or at risk for weight loss were changed to weekly weights and other interventions were implemented. Meal cards are consistently used on all trays at all meals.</p> <p>2. All licensed nurses will be re-educated by the consultant pharmacist on tube feeding policy and procedures, and will also be educated on adequate intake and output regarding residents who receive tube feeding. Dietary and nursing staff were re-educated on the importance of using the meal cards and placing them on the tray to ensure accurate meal plans are followed. A weekly Wound and Weight committee was started to include the MDS Case Managers, Director of Nursing, the certified wound care nurse, and the</p>		

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F 325	<p>Continued From page 127</p> <p>Interview on 9/3/14 at 6:31 p.m. with registered nurse (RN) B regarding resident 14's tube feeding revealed: *There had been ongoing problems with the feeding pump not working properly. *The physician had ordered a feeding until 6:00 p.m. that night because of the pump problems.</p> <p>Record review on 9/3/14 of resident 14's medical record revealed he: *Had an admission date of 7/3/14. *Had physician's orders dated 7/3/14 for "NPO [no food by mouth] Diet" "Jevity 1.2 at 80 cc for 11 hours start at 0500 [5:00 a.m.] and end at 1600 [4:00 p.m.] 240 cc free water flush four times daily. *Had been on a tube feeding since admission. *Had a diagnosis that had included diabetes. *Had needed extensive assistance with his care. *Had lost a total of 4.7 pounds or 3.7 percent (%) of his weight within the first month of admission. *Had lost a total of 4.6 lb or 3.6% the first month after his admission. *Had lost a total of 3.8 lb or 3.0% the first two months after his admission. *He had a physician's order on 7/3/14 for "Weight Weekly."</p> <p>Review of resident 14's 7/7/14 Nutrition History &amp; Data Collection Form by the consultant registered dietitian (RD) revealed: *No nutritional assessment regarding nutritional adequacy of calories, protein, or fluids. *He had a low albumin (a measurement of protein in the blood) level of 3.4 grams(g)/deciliter (dl). -A normal reference range for albumin would have been 3.5 through 5.0 g/dl.</p>	F 325	<p>consultant Registered Dietitian to review all residents at risk for weight loss and/or wound management needs.</p> <p>3. At monthly QAPI meeting, the Director of Nursing and the Registered Dietitian will provide a collaborative report, on a continuous basis, about effectiveness on the education on the tube feeding policy and procedures, the weekly weight process, and use of the meal cards to ensure outcomes reflect an understanding and implementation of effective practices. Based on report, further education and/or corrective action will be planned and carried out.</p>	

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F 325	<p>Continued From page 128</p> <p>Review of resident 14's 7/11/14 Interdisciplinary Progress Notes by the consultant RD revealed: *His tube feeding was his primary means of nutrition. *No nutritional assessment had been done regarding nutritional adequacy of calories, protein, or fluids. *His feeding was to have provided 100% of his total nutrient needs as well as his water needs. *"His weight is stable."</p> <p>Review of resident 14's 8/24/14 Interdisciplinary Progress Notes by the consultant RD revealed: *"Overall stable for nutrition." *No nutritional assessment had been done regarding nutritional adequacy of calories, protein, or fluids.</p> <p>Review of resident 14's I/O (Intake/Output) Chart Detail Report from 8/28/14 through 9/4/14 revealed: *He had an average daily intake of 662 cc. *There was no output on the report form. *That intake was less than half of what he should have received according to his physician's orders for the tube feeding and the water flushes for a total of 1673 cc per twenty-four hours.</p> <p>Interview on 9/4/14 at 8:15 a.m. with the director of nursing (DON) regarding resident 14 revealed: *There had been problems with his feeding pump not working properly and "beeping." *A new feeding pump had been obtained on 9/3/14. *She agreed there had not been accurate tracking on how much formula he had received since admission because of the problems with the pump. *There had been poor documentation of the</p>	F 325		

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F 325	<p>Continued From page 129 resident's intake of his tube feeding and water.</p> <p>Review of resident 14's 7/22/14 care plan revealed: *"I want to maintain my weight." *"Monitor my weights." *There was no documentation in his care plan regarding the weight loss.</p> <p>Review of resident 14's weight sheet from the first week in July 2014 through the first week in September 2014 revealed *The weekly weights were not completed for: -July, weeks two and four. -August, weeks three and four.</p> <p>Interview on 9/9/14 at 10:35 a.m. and at 2:30 p.m. with the consultant RD regarding resident 14 revealed: *She stated she had been aware of his weight loss. *Weekly weights had not been consistently obtained. *Expected his care plan to have been updated with the weight loss. *His albumin level had been low. *His protein level needed to have been increased in his tube feeding. *Had not included nutritional adequacy of calories, protein, and fluids in her assessments. *His tube feeding pump had not been working properly. *His weight loss reflected an estimated 275 calories less per day than his needs. *Those calories would have maintained his weight and prevented weight loss. *She stated he had not received all the tube feeding as ordered that contributed to the weight loss.</p>	F 325			

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F 325	Continued From page 130  Review of the provider's 2/16/14 Clinical Nutrition Services policy revealed the consultant RD was to have been responsible for completing a monthly tube feeding assessment that included nutritional adequacy of calories, protein, and fluids.  Review of the provider's 10/5/12 Enteral Nutrition/Hydration policy revealed: *Documentation guidelines included: -Type and amount of feeding and water administered. -Intake every shift. -Output recorded every shift. -If feeding was held. -Physician notification as necessary.  Review of the provider's undated Documentation Guidelines policy regarding tube feedings revealed there was to have been: *Nutrient used. *Amount and rate. *Number of cc and calories in twenty-four hours. *Weight.  Review of the provider's revised 7/16/14 Serving of Food policy revealed nursing was responsible for the feeding of tube-fed residents.  Refer to F322, finding 2. Surveyor: 33265 2. Observation on 9/3/14 from 5:15 p.m. through 5:30 p.m. of resident 9 revealed: *His feeding tube (tube going directly into ) was not connected and the feeding pump was not infusing at 5:15 p.m. *His feeding tube was connected and the feeding pump was infusing at 5:30 p.m.	F 325			

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F 325	<p>Continued From page 131</p> <p>*No one had entered his room during that time frame.</p> <p>*Resident had history of connecting and disconnecting his own feeding tube to the feeding pump.</p> <p>Review of resident 9's complete medical record revealed:</p> <p>*An interdisciplinary progress note on 6/15/14 at 5:00 p.m. that described the resident adjusting the rate of his feeding on his tube feeding pump.</p> <p>-Rate had been at 186 cubic centimeters (cc) per hour instead of the 85 cc per hour ordered.</p> <p>*Physician's orders to:</p> <p>-Check feeding tube placement before each feeding was dated 8/13/12.</p> <p>-Give a 200 cc flush of water through the feeding tube before and after each feeding was dated 8/12/13.</p> <p>-Jevity (nutritional solution to go through feeding tube in place of meals) 1.0 was to have been infusing at 85 cc per hour for sixteen hours (5:00 p.m. to 9:00 a.m.) was dated 5/27/14.</p> <p>-Jevity 1.0 was to have been infusing at 200 cc per hour for one and a half hours each noon was dated 6/23/14.</p> <p>-A 200 cc flush of water was to be one through the feeding tube every four hours was dated 7/23/14.</p> <p>Interview on 9/3/14 at 5:37 p.m. with RN B revealed she:</p> <p>*Was aware resident 9 had been starting and stopping his tube feeding himself.</p> <p>*Agreed there was no date or time documented on the Jevity solution container.</p> <p>*Agreed he might not have been getting the correct amount of Jevity or fluids ordered by the physician.</p>	F 325			

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F 325	<p>Continued From page 132</p> <p>*Agreed the assessments and water flushes might not have been done as ordered by physician.</p> <p>*Was not sure the date or time the current container of feeding solution had been hung.</p> <p>Observation on 9/8/14 from 12:00 p.m. (noon) to 1:07 p.m. of resident 9 revealed: *At 12:00 p.m. (noon), 12:21 p.m., and 12:40 p.m., his feeding tube was not connected or infusing. *At 12:44 p.m. his visitor left. The feeding tube was not connected or infusing at that time. *At 12:53 p.m. the feeding tube was connected to the solution and infusing at 250 cc per hour instead of the physician's ordered 200 cc per hour. *No one had entered the room since the visitor left.</p> <p>Interview on 9/8/14 at 1:08 p.m. with RNA regarding resident 9's feeding tube orders revealed she: *Believed his next feeding was at 5:00 p.m. *Stated he needed his every four hour 200 cc water flush done and proceeded to the resident's room. *Identified the feeding tube was infusing at that time. *She stopped the feeding pump and disconnected the feeding tube to administer the water flush. *She reconnected the feeding tube. *She restarted the feeding pump. *She asked the resident if he had connected his feeding tube and started his feeding. The resident stated he had. When asked why he stated no one came at noon to start it. *She was aware that resident 9 had been starting</p>	F 325		

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F 325	<p>Continued From page 133 and stopping his feeding himself. *She agreed the resident had connected and started his own noon feeding without an assessment of the feeding tube placement or a water flush before starting it. *She agreed he might not have been getting the correct amount of water or Jevity solution ordered by the physician.</p> <p>Review of resident 9's intake and output record from 6/12/14 to the present date revealed: *Inconsistent charting of feeding tube water flushes as ordered by the physician. *Occasional documentation of 300 cc 12:00 p.m. (noon) feeding tube fluid, but rare documentation of sixteen hour overnight feeding (from 5:00 p.m. to 9:00 a.m.) fluid which would have been 1,360 cc with the present physician orders. *No documentation of output had been kept.</p> <p>Review of resident 9's medication administration record for September 2014 revealed: *The feeding tube fluid was to be infused twice a day from 5:00 p.m. to 9:00 a.m., and 12:00 p.m. (noon), to 1:30 p.m. *The water flushes before and after feedings were set for 4:00 a.m., 12:00 p.m.(noon), and 5:00 p.m. -The times should have been 12:00 p.m. (noon), 1:30 p.m., 5:00 p.m., and 9:00 a.m. *The every four hour water flush was set for 1:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m. (noon), and 5:00 p.m. -There should have been six times not five. -At these scheduled times the tube feeding was infusing or there was another order for the tube to be flushed. -There was no documentation on clarification of these doubled flush orders with the physician.</p>	F 325			

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F 325	Continued From page 134  Review of resident 9's nutritional assessments by the consultant registered dietician (RD) revealed: *No monthly assessment was documented for July 2014. *An assessment on 8/24/14 titled quarterly assessment revealed the RD consultant: -Calculated the feeding formula measurement for each day using 85 cc per hour for fourteen hours instead of the sixteen hours that was ordered (5:00 p.m. to 9:00 a.m.). The missing two hours of formula would change the figures for the amount of calories and protein received. -Calculated the resident would need one 1500 cc container of the feeding formula (Jevity) every twenty-four hours. The missing two hours would have required part of a second container being used each twenty four hour period. -Calculated the free water by including the 200 cc every four hours, but did not include the 200 cc before and after each feeding time (two times per day), which would add another 800 cc to the free water calculation. -She was aware the resident was adjusting the rate on his feeding tube pump. Surveyor: 32335 B. Based on observation, record review, interview, and policy review, the provider failed to ensure a therapeutic diet of fortified foods (have added vitamins and minerals) had been followed for one of one sampled resident (5) in the memory care unit who had lost weight. Findings include:  1. Review of resident 5's weight records revealed she had weighed 145.0 pounds (lb) in February 2013. In March 2014 her weight had dropped to 139.4 lb. That was a 3.9% weight loss.	F 325			

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F 325	Continued From page 135  Review of resident 5's interdisciplinary notes revealed a note dated 3/6/14 from the RD that stated "eats well, although with her recent weight drop, we did add fortified foods, to avoid any further slide."  Observation and interview on 9/3/14 at 5:15 p.m. with CNA Q regarding the supper meal in the memory support unit revealed: *The food trays were not identified with residents' names. *There were no diet cards on the food trays. *She delivered the textured diet trays to the three residents that had those diets. *The rest of the trays she delivered in no particular order.  Review of resident 5's CNA hand-written weight records revealed she had gone from 135.8 lb in May 2014 to 128.4 lb in June 2014. The weight loss had been a significant weight loss of 5.4%.  Review of resident 5's medical record revealed there was no documentation from the CNAs, RNs or RD regarding the significant weight loss or additional interventions attempted. In September 2014 her weight was 127.2 lb.  Review of resident 5's 6/2/14 and 8/25/14 MDS assessments revealed she had not been identified as having weight loss.  Review of resident 5's undated care plan revealed there were no goals or interventions regarding her weight loss. There were no goals or interventions that identified she was at risk for weight loss.	F 325			

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F 325	<p>Continued From page 136</p> <p>Interview and record review on 9/9/14 at 9:05 a.m. with the RD regarding resident 5 revealed: *By using the CNA hand-written weight records she calculated the weight loss to be 5.4%. *When she was in the facility reviewing weight losses she would run a report called a "Significant Weight Change Report." *On that report the resident's weight loss had recorded as 4.9% instead of 5.4% *The report rounded the weight information up or down. *She was unsure why the report had done that. *She documented on weight loss of 5% or greater. *She should have documented on the 4.9% weight loss, because it was so close to 5%. *She had been unaware of the diet cards not being sent on the food trays to the memory care unit.</p> <p>Observation and interview on 9/10/14 at 7:50 a.m. in the memory care unit revealed CNA S was delivering the food trays. There were no diet cards or names on the trays. She agreed they had not known if resident 5 had been getting the fortified foods.</p> <p>Interview on 9/10/14 at 8:45 a.m. with the DM revealed staff were to have sent the diet cards on the food trays to the memory care unit. She was unaware they had not been sending them.</p> <p>Review of the provider's 12/11/12 Weight and Height policy revealed: **If any resident has a 5 pound weight variance from their previous weight, the CNA will immediately re-weigh the resident. *If the 5 pound weight variance continues, the following will be completed:</p>	F 325			

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F 325	Continued From page 137 -The CNA will inform the nurse of the 5 pound weight variance. -The charge nurse will assess/evaluate probable causes for the weight variances. -The charge nurse will notify the dietician of all 5 pound weight variances, along with probable causes identified. -The dietician will notify the appropriate parties (physician and family) regarding the weight variance."  Review of the provider's 5/29/03 Clinical Nutrition Services policy revealed: *"The consulting RD was responsible for completing a nutrition assessment for each resident admitted to the facility and upon a significant change. *Nutrition assessments must be completed prior to developing the resident assessment and care plan. *Progress notes are maintained for each resident in the facility and reflect progress and response to his/her care plan. *Progress notes are recorded whenever changes occur in the resident's condition and at least quarterly."	F 325			
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION  The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.  This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on record review, interview, and policy	F 327	1. Clinical record review for Residents 12 and 13 determined the residents had no negative outcome related to inadequate fluid intake. All residents who are dependent on staff for hydration were reviewed to determine no negative outcomes related to hydration status.	10/10/14	

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F 327	<p>Continued From page 138</p> <p>review, the provider failed to ensure required hydration (To supply water to a person in order to restore or maintain fluid balance) needs for two of two residents (12 and 13) dependent on staff for hydration, were met resulting in the potential for harmful effects from dehydration (an abnormal loss of water from the body, especially from illness or physical exertion). Findings include:</p> <p>1a. Review of the medical records for resident 12 revealed: *He had a diagnosis of dementia (declining mental function). *He was a known risk for dehydration. *He required staff to supervise and feed him at the time of the survey. *He required 30 milliliters (ml) of fluid per kilogram of body weight (90 kg) based off his weight of 199 lbs noted on 9/1/14 . That weight would require 2,713 ml of fluid per day to maintain hydration. Fluid records documented from 9/4/14 through 9/9/14 revealed he received on average 1,183 ml of fluid per day, less than half of his needed hydration.</p> <p>b. Review of the medical record for resident 13 revealed: *She had a diagnosis of dementia. *She was known for risk of dehydration. *She required staff to feed her at the time of the survey. *She required 30 ml of fluid per kg of body weight (71kg). That weight would require 2,154 ml of fluid per day to maintain hydration. Fluid records documented from 8/31/14 through 9/9/14 revealed she received on average 810 ml of fluid daily, less than half of her needed hydration.</p> <p>c. Interview on 9/9/14 at 2:45 p.m. with nursing</p>	F 327	<p>2. A hydration input record was developed to monitor for adequate fluid intake. Nursing staff were educated on the use of the hydration input record. The consultant Registered Dietitian will review the input records for all residents who are dependent on staff for hydration and will report any issues at the weekly Wound and Weight committee meeting.</p> <p>3. At monthly QAPI meetings, the Director of Nursing and consultant Registered Dietitian will provide a collaborative report, on a continuous basis, about effectiveness on the education of the hydration input record. Based on report, further education and/or corrective action will be planned and carried out.</p>		

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F 327	Continued From page 139 assistant (NA) JJ regarding residents on the east wing revealed: *Both of the above residents were dependent upon staff for hydration. *She had been employed "about a month and a half" and was not certified yet. *They were "short-staffed and residents were lucky to get good care."  Interview on 9/10/14 at 2:00 p.m. with registered nurse (RN) A regarding residents 12 and 13 revealed: *Residents who were dependent on staff for hydration had not been getting fluids between meals as staffing was poor. *Bedtime snacks were routinely not given or residents were often sleeping when staff had been offering them, which had been related to the lack of staff available. *She agreed more staff were needed in the facility and had been for a "very long time." *She was doing her best but felt she "had no time."  Review of the provider's 8/11/09 Hydration Policy and Procedure policy revealed: *All residents would be offered a minimum of 1500 cc (same measurement as an ml) of fluid per day. *Nursing staff would assist dependent residents.	F 327			
F 332 SS=E	Refer to F314. 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.	F 332			

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F 332	Continued From page 140  This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation and interview, the provider failed to ensure a less than a 9.5 percent (%) medication error rate (four medication errors out of forty-two opportunities for medication error) for one of ten sampled residents (9) who received medications through a gastrostomy tube (tube into the stomach). Findings include:  1. Observation on 9/4/14 at 8:15 a.m. of registered nurse (RN) A revealed she: *Crushed a lisinopril tablet and a Tamsulosin tablet. *Put the above crushed tablets into 5 milliliters (ml) of Senexon liquid and 30 ml of liquid fiber supplement. *Crushed a metoprolol tablet and placed it into a separate plastic medication cup with a small amount of water.  Interview at that time with RN A regarding resident 9 revealed: *He was to also receive 200 ml of water at that time. *She would give 100 ml of water before giving the cup of medications that contained the lisinopril, the Tamsulosin, the Senexon liquid, and the liquid fiber supplement. *She would administer the metoprolol separately after she had taken his pulse to make sure it was over 60. She did not mix the metoprolol with the above solution in case his pulse was not above 60. *After she had administered the above medication, she would give the other 100 ml of	F 332	1. Clinical record review for Resident 9 and all residents with tube feeding determined there was no negative outcome related to the administration of all medications at the same time. The Registered Dietitian has set-up a schedule for Resident 9's tube feedings so that he will be able to participate in activities as desired. 2. All licensed nurses will be re-educated by the consultant pharmacist on tube feeding policy and procedures. 3. At monthly QAPI meeting, the Director of Nursing and the Registered Dietitian will provide a collaborative report, on a continuous basis, about effectiveness on the education on the tube feeding policy and procedures to ensure outcomes reflect an understanding and implementation of effective practices. Based on report, further education and/or corrective action will be planned and carried out.	10/10/14	

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F 332	Continued From page 141 water. Surveyor: 33265 Continued observation of RN A regarding resident 9's above medication administration revealed: *She gave all of the medications through the feeding tube. *She gave metoprolol as a separate medication. *She combined the four other medications lisinopril, Senexon, tamsulosin, and liquid fiber supplement together and administered them at one time instead of as four separate medications with flushes between them.  Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th ED., St. Louis, MO, pg. 594, revealed "When administering more than one medication at at time, give each separately and flush between medications with at least 15 ml of water."	F 332			
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Surveyor: 22452 A. Based on observation, record review, interview, and policy review, the provider failed to accurately and professionally administer medications according to the physicians' orders for: *One of one sampled resident (2) who had received Ativan (an anti-anxiety medication). *Three of three randomly observed residents (40, 46, and 48) during oral administration of an	F 333	1. Observation of Resident 3 and review of the clinical record determined there was no further negative outcome related to the significant medication errors. The Licensed Practical Nurse (LPN) K was counseled on appropriately measuring medication. The Medication Administration Records (MARs) for all residents in September 2014 were reviewed for documentation gaps and reconciled with current orders.	10/10/14	

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F 333	<p>Continued From page 142 anti-anxiety medication, eye drop, and inhaler administrations. Findings include:</p> <p>1. Review of resident 40's August 2014 and September 2014 narcotic records revealed: *No documentation lorazepam (anti-anxiety medication) 0.5 milligrams (mg) ordered daily had been administered on 8/13/14 and 9/3/14. *There was no documentation why the lorazepam had not been administered.</p> <p>Interview on 9/4/14 at 7:55 a.m. with medication technician (tech)/certified nursing assistant (MT/CNA) LL regarding the above revealed: *She confirmed there was no documentation on the narcotic record a lorazepam tablet had been removed from the medication card on 8/13/14 or on 9/3/14. *The lorazepam was documented as administered on the medication administration record (MAR) for 8/13/14 and 9/3/14. *The medication count in the lorazepam card revealed the lorazepam had likely not been administered on 8/13/14 or 9/3/14. The lorazepam medication card had started on 8/13/14 with thirty tablets. There were now eight tablets of lorazepam in the medication card and there should have been six tablets.</p> <p>2. Review of the 8/19/14 pharmacy re-order sheet for resident 46 revealed "Lumigan eye drops for (glaucoma) refill. No medication available since 8/10/14."</p> <p>Review of resident 46's August 2014 MAR revealed the Lumigan eye drops had been circled from 8/10/14 through 8/19/14 "No medication available."</p>	F 333	<p>2. All licensed staff were educated on ensuring documentation for medication administration is completed and measurement of medications is accurate. The Medical Records Coordinator will review the MARs for documentation gaps for all residents for October 2014, and then random audits for 20% of the MARs for 90 days. Identified medication errors will be reported to the Director of Nursing, who will retain medication error records to determine the monthly medication error rate and whether any errors are significant. When system is determined to be in place, the audits will be discontinued. The consultant pharmacist will educate nursing staff on the policy and procedures related to medication administration, reconciliation of controlled substances, and storage of medications.</p>		

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F 333	<p>Continued From page 143</p> <p>Review of resident 46's September 2014 MAR revealed the Lumigan eye drops had been circled on 9/1/14 and 9/2/14 "No medication to give."</p> <p>3. Review of resident 48's August and September 2014 MARs revealed: *Advair (inhaler for asthma and chronic obstructive pulmonary disease) one puff twice a day (BID). *The Advair inhaler had been documented as administered for all the doses.</p> <p>Observation on 9/10/14 at 12:45 p.m. of resident 48's Advair inhaler in the medication cart revealed: *The inhaler had been opened on 8/22/14 and contained sixty doses. *There were thirty-four doses left in the inhaler. *There should have been twenty-one doses left if the Advair inhaler had been administered twice a day as ordered by the physician.</p> <p>Interview on 9/10/14 at 12:50 p.m. with MT/CNA LL regarding resident 48 revealed there was a discrepancy between the doses of Advair left in the inhaler and what had been documented.</p> <p>4. Interview on 9/10/14 at 12:55 p.m. with the director of nursing (DON) regarding the above residents revealed she: *Was not aware of any of the above medication discrepancies or omissions. *Agreed those were medication errors and had the potential for harm of increased anxiety, increased eye pressure, and increased shortness of breath. *Confirmed they had recently had new nurses.</p>	F 333	3. At the monthly QAPI meeting, the Director of Nursing will provide a report, on a continuous basis, about the effectiveness of the education based on the medication error rate.		

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F 333	<p>Continued From page 144</p> <p>Review of the provider's 10/28/13 Pharmacy Services-Role of the Provider Pharmacy policy revealed "The facility shall have a written agreement with a provider pharmacy to provide regular and reliable pharmacy services to residents, including medications, services, and related equipment and supplies."</p> <p>Review of the provider's 10/28/13 Medication Orders policy revealed "Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three days prior to the last dosage being administered to ensure that refills are readily available."</p> <p>Review of the provider's 10/23/13 Medication Therapy and Administration policy revealed:                      "All medications shall be administered in a safe and timely manner."                      "The DON will supervise and direct all nursing personnel who administer medications and/or have related functions."                      "Medications must be administered in accordance with orders."                      "The charge nurse must accompany new nursing personnel on their medication rounds for a minimum of three days to ensure established procedures are followed and proper resident identification methods are learned."                      "Medication related issues will be part of the quality assurance/performance improvement committee."                      Surveyor: 30170                      B. Based on record review and interview, the provider failed to ensure the correct dosing and administration of Ativan (anti-anxiety) medication administered by one of one licensed practical nurse (LPN) K for one of one sampled resident (2). Findings include:</p>	F 333			

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F 333	Continued From page 145  1. Review of resident 2's August 2014 medication administration record (MAR) and the Antipsychotic Monitoring Tool form revealed: *There was a physician's order for Ativan 2 milligrams (mg) per milliliter (ml) administer 0.25 ml to 0.5 ml po (orally) or SL (sublingual [under the tongue]) every four hours as needed (PRN) for anxiety. *On 8/28/14 at 8:00 p.m. LPN K had administered Ativan 1 cc (equivalent to 1 ml) which would have been 2 mg, because the resident had been "agitated with cares." That was an incorrect dose. She had administered twice the prescribed dose. *On 8/29/14 at 2:00 a.m. LPN K had administered another incorrect dose of Ativan. She had administered 1 cc orally for "agitation with cares."  Interview on 9/3/14 at 4:00 p.m. with the director of nursing (DON) regarding the above record review revealed: *She had been unaware there was an incorrect dose of Ativan administered to resident 2. *She agreed the resident had been given twice the physician ordered dose of Ativan. *The resident could have been severely injured with that incorrect dose of Ativan.  Interview on 9/4/14 at 10:30 a.m. with the DON regarding LPN L that had been involved in administering the incorrect dose of Ativan to resident 2 revealed: *She had spoken to LPN L on the phone regarding the medication error. *LPN L had stated she had not been feeling well that night. *That had been LPN L's reason for the medication error.	F 333			

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F 333	<p>Continued From page 146</p> <p>Anonymous interview on 9/10/14 at 3:00 p.m. regarding resident 2 revealed:</p> <ul style="list-style-type: none"> <li>*The next day after he had received the Ativan he was hard to arouse.</li> <li>*He had gone all day without eating, because he had been too sleepy.</li> <li>*He had slept most of the next day after he had received the Ativan.</li> </ul> <p>Telephone interview on 9/11/14 at 11:30 a.m. with LPN L and business manager O revealed:</p> <ul style="list-style-type: none"> <li>*She was aware a medication error had occurred with resident 2's Ativan.</li> <li>*She stated she had not been feeling well that night, and that was the reason she had administered the incorrect dose of Ativan.</li> <li>*Resident 2 was swinging and had attempted to hit her and another co-worker as they were attending to him. She administered the Ativan to stop him from hitting at them.</li> </ul> <p>Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 582, revealed:</p> <ul style="list-style-type: none"> <li>**Administering medications to patients requires knowledge and a set of skills that are unique to a nurse. You first assess that the medication ordered is the correct medication.</li> <li>*A medication error can cause or lead to inappropriate medication use or patient harm. Medication errors include inaccurate prescribing, administering the wrong medication, giving the medication using the wrong route or time interval, and administering extra doses or failing to administer a medication. Preventing medication errors is essential. Because nurses play an essential role in preparing and administering medications, they need to be vigilant in preventing errors. Medication errors are related to</li> </ul>	F 333		

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F 333	Continued From page 147 practice patterns, health care product design, or procedures and systems such as product labeling and distribution."	F 333			
F 353 SS=1	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, and interview, the provider failed to ensure adequate staff on a twenty-four hour period to ensure all the residents' basic needs were met according to their plans of care. Findings include:</p>	F 353	<p>1. The facility participated in a job fair on 9/24/14. Open staff positions continue to be advertised with a starting bonus for CNAs and LPN or RNs starting 9/21/14. Nine CNAs have started since 9/10/14. Contact with temporary staffing agencies continues for both day and night shifts. An hourly pay differential was initiated for staff working on the night shift. A Staff Development Coordinator was hired; start date 10/7/14.</p> <p>2. A recruitment and retention plan will be developed with a staffing committee on or before the 10/10/14. The Advancing Excellence consistent assignment and staff satisfaction tools will be utilized with this committee activity. The Director of Nursing will have a face-to-face meeting with the staffing scheduler in the morning about day shift and prior to the night shift to discuss adequacy</p>	10/10/14	

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F 353	Continued From page 148 1. Interview on 9/4/14 at 10:30 a.m. with business manager O regarding staffing revealed she: *Had been doing scheduling for about a month and one-half to two months. *Had been put in the position the end of July 2014 after the human resource staff person who had been doing the scheduling left. She had received minimal training for the position. *Had been trying to cover open nursing shifts with the staff they had. *Had been calling three staffing agencies in conjunction with the administrator to fill open nursing spots with little success. *Stated two staffing facilities had not been able to supply them with any staff. *Stated one staffing facility had sent them a certified nursing assistant (CNA) on 8/27/14 and on 9/9/14. They had sent them a licensed practical nurse on 9/7/14 that had been utilized as a CNA. *Knew there were shifts that were not fully covered with nurses and CNAs. *Stated the nurses usually worked twelve hour shifts 6:00 a.m. to 6:30 p.m. or 6:00 p.m. to 6:30 a.m. *Stated the medication technicians (MT)/CNA usually worked the same twelve hour shifts. Some of the MT/CNAs worked eight hour shifts. *Stated the CNAs also usually worked twelve hour shifts. Some CNAs would work eight hour shifts or any amount of hours that would help fill in hours. *Stated the adequate amount of nursing staff for the twenty-four hour period would be as follows: -One nurse on each wing from 6:00 a.m. to 6:30 p.m. and from 6:00 p.m. to 6:30 a.m. (Warren wing, east wing, and center wing). -Usually a med tech/CNA would staff the memory care unit instead of a nurse for a twelve hour shift	F 353	of staffing and assignments. This will occur Monday – Friday; the weekend staffing will be reviewed on Friday. A checklist of duties for the weekend manager on duty will be developed and the MOD will be expected sign and date that form. The MOD will be responsible to contact the Administrator and Director of Nursing as directed by facility policies related to grievances, incidents/occurrences, and staffing concerns. A competency evaluation plan upon hire and annually will be developed to determine necessary education needs. 3. The Administrator will provide a report at the monthly QAPI meeting, on a continuous basis, regarding staffing levels, staffing satisfaction, and staffing turnover. The report will also include progress on the recruitment and retention committee, the MOD process, and well as competency evaluation program.		

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F 353	<p>Continued From page 149</p> <p>from 6:00 a.m. to 6:30 p.m. and from 6:00 p.m. to 6:30 a.m.</p> <p>-Four CNAs would work the center wing from 6:00 a.m. to 6:30 p.m. twelve hour shifts.</p> <p>-Three CNAs would work the east wing from 6:00 a.m. to 6:30 p.m. twelve hour shifts.</p> <p>-One CNA would work the Warren wing from 6:00 a.m. to 6:30 p.m. a twelve hour shift.</p> <p>-One CNA would work in the memory care unit from 6:00 a.m. to 6:00 p.m. a twelve hour shift.</p> <p>-Two to three CNAs would work the center wing from 6:00 p.m. to 6:30 a.m. twelve hour shifts.</p> <p>-Two CNAs would work the east wing from 6:00 p.m. to 6:30 a.m. twelve hour shifts.</p> <p>-One CNA would work in the memory care unit from 6:00 p.m. to 6:30 a.m. a twelve hour shift.</p> <p>-One MT/CNA on both the east wing and the center wing from 6:00 a.m. to 6:30 p.m. a twelve hour shift.</p> <p>-One MT/CNA on both the east wing and the center wing from 6:00 p.m. to 6:30 a.m. a twelve hour shift.</p> <p>*If there was not a nurse in the Warren wing from either 6:00 a.m. to 6:30 p.m. or from 6:00 p.m. to 6:30 a.m. they would leave the doors to the unit open, and the nurse from the east or the center wings would cover that area too.</p> <p>Review of the 8/18/14 through 9/7/14 nursing schedules revealed deviations from the above adequate staffing on the following dates: *8/18/14, Two CNAs worked 6:00 a.m. to 6:30 p.m. on the center wing instead four CNAs. Two CNAs worked from 6:00 a.m. to 6:30 p.m. on the east wing instead of three. One CNA worked the east wing from 6:00 p.m. to 6:30 a.m. instead of two. *8/19/14, Two nurses worked from 6:00 p.m. to 6:30 a.m. instead of three.</p>	F 353			

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F 353	Continued From page 150 *8/22/14, Two nurses worked from 6:00 p.m. to 6:30 a.m. instead of three. *8/23/14, Two nurses worked from 6:00 p.m. to 6:30 a.m. instead of three twelve hour shift nurses. One nurse worked 6:00 p.m. to 10:00 p.m. (short an 8 hour nurse). *8/24/14, Two CNAs worked from 6:00 a.m. to 6:30 p.m. on the center wing instead of four. Two CNAs worked from 6:00 a.m. to 6:30 p.m. on the east wing instead of three. There was not a CNA in the Warren wing from 6:00 a.m. to 6:30 p.m. One CNA worked from 6:00 p.m. to 6:30 a.m. on the center wing instead of two. *8/25/14, Two nurses worked from 6:00 a.m. to 6:30 a.m. instead of three. Two CNAs worked from 6:00 a.m. to 6:00 p.m. on the east wing instead of three. One CNA worked on the center wing from 6:00 p.m. to 6:30 a.m. instead of two. *8/26/14, Two CNAs worked the center wing from 6:00 a.m. to 6:30 p.m. instead of four. Two CNAs worked the east wing from 6:00 a.m. to 6:30 p.m. instead of three. One CNA worked the center wing from 6:00 p.m. to 6:30 a.m. instead of two. *8/27/14, Two nurses worked from 6:00 p.m. to 6:30 a.m. instead of three. Three CNAs worked the center wing from 6:00 a.m. to 6:30 p.m. instead of four. *8/28/14, Two nurses worked from 6:00 p.m. to 6:30 a.m. instead of three. One MT/CNA worked from 6:00 p.m. to 6:30 a.m. instead of two. *8/29/14, Three CNAs worked the center wing from 6:00 a.m. to 6:30 p.m. instead of four. *8/30/14, Three CNAs worked the center wing from 6:00 a.m. to 6:30 p.m. instead of four. *8/31/14, Two CNAs worked the center wing from 6:00 a.m. to 6:30 p.m. instead of four. Two CNAs worked the east wing from 6:00 a.m. to 6:30 p.m. instead of three. Two CNAs worked the east wing from 2:00 p.m. to 9:00 p.m. No CNAs were	F 353			

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F 353	<p>Continued From page 151</p> <p>scheduled after 9:00 p.m. to 6:30 p.m.</p> <p>*9/4/14, Three CNAs worked the center wing from 6:00 a.m. to 6:30 p.m. instead of four.</p> <p>*9/5/14, Two nurses worked from 6:00 p.m. to 6:30 p.m. A licensed practical nurse also worked from 6:00 p.m. to 6:30 a.m. but was in orientation. One CNA worked from 2:00 p.m. to 10:00 p.m. Two CNAs worked from 6:00 p.m. to 6:30 a.m. to cover the whole facility.</p> <p>*9/6/14, Two nurses worked from 6:00 p.m. to 6:30 a.m. instead of three. Four CNAs worked from 6:00 p.m. to 6:30 a.m. to cover the facility instead of six.</p> <p>*9/7/14, Two nurses worked from 6:00 p.m. to 6:30 a.m. instead of three.</p> <p>Surveyor: 33265</p> <p>2. One hour observations were completed two times a day, each day, during the three days of 9/5/14, 9/6/14, and 9/7/14, for a total of six different observations. During each of these observations the staff that were present was compared to the daily staffing planned. This revealed that during each twelve hours shift:</p> <p>*There were numerous schedule changes from the staffing plan provided on 9/4/14.</p> <p>*The provider had not been able to secure the identified adequate number and type of staff needed each shift to provide for the basic needs of the residents.</p> <p>Observation on 9/5/14 from 10:48 a.m. through 11:50 a.m. concerning staffing for the day shift from 6:00 a.m. to 6:00 p.m. revealed:</p> <p>*Center wing: with forty-six residents:</p> <p>-There were two CNAs scheduled for the two hours between 2:00 p.m. and 4:30 p.m.</p> <p>-There was one CNA scheduled for the two hour period between 4:30 p.m. and 6:30 p.m. which would include getting residents to dinner and</p>	F 353			

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F 353	<p>Continued From page 152</p> <p>back to their rooms after dinner.</p> <p>-They had pulled a MT/CNA from east wing from 5:00 p.m. to 6:00 p.m. to help on the center wing during the dinner time period.</p> <p>*East wing with thirty-two residents:</p> <p>-The scheduled MT/CNA was now orienting a new staff person.</p> <p>*Warren wing with five residents:</p> <p>-There was one CNA scheduled for an eight hour shift. At the time of the observation the schedule had been changed, and that person was staying for a total of eleven hours.</p> <p>-There was one nurse scheduled for a twelve hour shift. No nurse was present at the time of the observation, and no one had been found to fill in for that nurse. There was no one assigned for the last hour. Center wing staff was to address the needs of Warren wing residents during that time.</p> <p>Observation on 9/5/14 from 9:00 p.m. through 10:00 p.m. concerning staffing for the night shift from 6:00 p.m. to 6:00 a.m. revealed:</p> <p>*Center wing with forty-six residents:</p> <p>-The evening/bedtime snack cart was sitting at the nurses station. The food bin with snacks and food had some ice remaining, and more than half of the bin was full of food items.</p> <p>-They had pulled a MT/CNA from the east wing to work on center between 6:00 p.m. and 8:00 p.m.</p> <p>-At 9:00 p.m. there were four residents' call lights on, and two residents were in wheelchairs against a wall by the nurses station waiting to be assisted to bed.</p> <p>-They had one CNA scheduled for an eight hour shift. That person was to be there until 10:30 p.m.</p> <p>- After 10:30 p.m. there would be one nurse and one MT/CNA for forty-six residents from 10:30 p.m. to 6:30 a.m. to answer lights, administer</p>	F 353		

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F 353	<p>Continued From page 153</p> <p>medications, and meet all resident needs.</p> <p>*East wing with thirty-two residents:</p> <ul style="list-style-type: none"> <li>-Evening/bedtime snack cart was sitting at the nurses station. The food bin with snacks and food had some ice remaining, and the food bin was full of food items.</li> <li>-There was one nurse present from 6:00 p.m. to 6:30 a.m.</li> <li>-One CNA had been scheduled from 6:00 p.m. to 8:00 p.m.</li> <li>-They had pulled one MT/CNA from the Warren wing for 6:00 p.m. to 6:30 a.m. to help on the east wing.</li> </ul> <p>*Warren wing with five resident had one nurse from 6:00 p.m. to the 6:30 a.m. shift.</p> <p>Interview on 9/6/14 at 11:45 a.m. with resident 35 revealed:</p> <p>*She required two staff to assist her in transferring using the Hoyer lift (mechanical device used to raise and lower residents).</p> <p>**"Only had one CNA on last night." "I need two people to help me." "Had to wait forever to go the the bathroom."</p> <p>Observation on 9/6/14 from 11:10 a.m. through 12:10 p.m. concerning staffing for the day shift from 6:00 a.m. to 6:00 p.m. revealed:</p> <p>*Center wing with forty-six resident:</p> <ul style="list-style-type: none"> <li>-There were no CNAs assigned and present for the entire twelve hour shift. Four CNAs were scheduled for parts of the twelve hour shift. One of those was only scheduled to be on center wing for two hours of the twelve hour shift.</li> </ul> <p>*East wing with thirty-two residents:</p> <ul style="list-style-type: none"> <li>-Two licensed practical nurses (LPN) had been assigned on the schedule to come in. One was an error.</li> <li>-One LPN was present during the twelve hour day</li> </ul>	F 353		

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F 353	<p>Continued From page 154 shift.</p> <p>-Only one CNA was assigned and present for the entire twelve hour shift. Three other CNAs were assigned and present for part of the twelve hour shift. One of those was only scheduled for four hours of the twelve hour shift.</p> <p>*Warren wing with five residents had one nurse for the day shift. No CNA was scheduled on that wing.</p> <p>Observation on 9/6/14 from 11:10 p.m. through 9/7/14 at 12:10 a.m. concerning staffing for the night shift from 6:00 p.m. to 6:00 a.m. revealed:</p> <p>*Center wing with forty-six residents:</p> <p>-Evening/bedtime snack cart was sitting at the nurses station. The food bin with snacks and food had very little ice remaining, and more than half of the bin was full of food items.</p> <p>-The scheduled MT/CNA for center had to add the five residents from the Warren wing to her resident list.</p> <p>-One CNA remained on the center wing as the second one was pulled to the east wing to assist until people were in bed.</p> <p>-One nurse was present on the center wing.</p> <p>*East wing with thirty-two residents:</p> <p>-Evening/bedtime snack cart was sitting at nurses station. The food bin with snacks and food had very little ice remaining, and more than half of the bin was full of food items.</p> <p>-Four residents were seated in the nurses station, two of them were asleep in their chairs or wheelchairs. The third was yelling for help. The fourth was wheeling back and forth in the hall.</p> <p>-One CNA had gone on break at 7:15 p.m. and never returned. The nurse had reported her as missing to the police. The police had checked and found her at home in bed. She did not intend to return to work.</p>	F 353			

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F 353	<p>Continued From page 155</p> <ul style="list-style-type: none"> <li>-A second CNA had not shown up for work, had not called, and could not be reached.</li> <li>-One nurse and one CNA remained for the duration of the night shift to assist the residents.</li> <li>-A CNA from center wing was pulled to the east wing to assist until people were in bed. Once all were in bed she would be going home.</li> <li>-The nurse on duty had attempted to call all the off-duty staff to ask if they would come in and assist on the night shift. No one had agreed to come in. She then notified the manager on duty who had been the administrator at 11:55 p.m. She was instructed to call the LPNs and see if one would come in early tomorrow morning to assist in getting residents up after the nights sleep.</li> <li>*Warren wing with five residents had no staff were present. Center wing staff were to cover this wing also. To do so they:             <ul style="list-style-type: none"> <li>-Opened the double doors to the Warren wing so the Warren wing residents' call lights could be seen from the center wing.</li> <li>-Turned on all five resident call lights to identify where the residents were located.</li> <li>-If a Warren wing resident put on their call light the light would change from a steady beam to all three colors (white, red, and green) flashing with a fast audible tone to identify the immediate need for assistance.</li> </ul> </li> </ul> <p>Observation on 9/7/14 Sunday, from 9:40 a.m. through 10:40 a.m. concerning staffing for the day shift from 6:00 a.m. to 6:00 p.m. revealed:</p> <ul style="list-style-type: none"> <li>*The front desk receptionist was going through mail. She stated the mail was from Saturday. She had not had time to go through the mail on Saturday.</li> <li>*Center wing with forty-six residents:             <ul style="list-style-type: none"> <li>-Between 4:30 p.m. and 6:30 p.m. there were one</li> </ul> </li> </ul>	F 353			

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F 353	<p>Continued From page 156</p> <p>MT/CNA and one nurse on duty. During that time residents would have to get to the evening meal and be assisted following the meal.</p> <p>*East wing with thirty-two residents: -There was only one CNA scheduled for the full twelve hour shift. Three others were scheduled for part of a twelve hour shift. Two of those were for four hours of the twelve hour shift.</p> <p>*Warren wing with five residents: -Had one nurse scheduled for the twelve hour shift. No CNA was present on the Warren wing.</p> <p>Interview on 9/7/14 at 7:59 p.m. with resident 35 revealed: *She had put her call light on at 6:30 p.m. following the evening meal for the assistance of one person to place a bedpan under her. *She had finished and put her call light on at 6:40 p.m. to be taken off the bedpan. *She received assistance to get off the bedpan at 7:55 p.m. *She was in pain and was told there was a red area on her buttocks where the bedpan had been.</p> <p>Observation on 9/7/14 from 7:45 p.m. through 8:45 p.m. concerning staffing for the night shift from 6:00 p.m. to 6:00 a.m. revealed: *Center wing with forty-six residents: -Evening/bedtime snack cart was sitting at the nurses station, and more than half of the bin was full of food items. -The MT/CNA had been pulled from the center wing and sent to the Warren wing. -One nurse remained on the center wing. -There were two CNAs until 10:00 p.m. and a second nurse from 6:00 p.m. to 9:00 p.m. *East wing with thirty-two residents: -One nurse and one CNA were scheduled for the</p>	F 353			

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F 353	<p>Continued From page 157 entire night shift. -One MT/CNA was leaving at 9:00 p.m. -One other CNA was leaving at 10:30 p.m. -At 8:10 p.m. there were six residents seated at the nurses station area. Four of those were asleep in their chairs or wheelchairs. The fifth one was yelling for help. The sixth one was wheeling back and forth in the hall. -At 8:20 p.m. the administrator was wheeling the east wing's evening/bedtime snack cart to the east wing *One nurse from a temporary staffing agency was working the night shift and floating between the center and the east wings. *Warren wing with five resident: -Had one MT/CNA scheduled for the twelve hour shift. -A nurse had been listed on the Daily Employee Assignment Schedule form for that wing and shift, but that nurse was not present. Surveyor: 33488 Interview on 9/9/14 at 2:45 p.m. with nursing assistant (NA) JJ regarding residents on the east wing revealed: *She was unsure when or if any of the residents of the east wing needed to be repositioned or why. *She had been unaware residents 12 and 13 had pressure ulcers. *She had been employed "about a month and a half" and was not certified yet. *She stated they were "short-staffed and residents were lucky to get good care." *She was placed on a weight restriction for muscle strain from lifting residents at the time of the survey from lack of additional staff to help. *She was "lucky to have another aide working on the wing today." *Stated both residents 12 and 13 were dependent</p>	F 353		

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F 353	<p>Continued From page 158 on staff for fluid and nutrition. *She was unsure how she and the other CNA would be able to transfer residents requiring an assist of two safely or at all if she was unable to lift (with her 5 lb. weight restriction). *Average time to answer a call light on the east wing she estimated, had been twenty minutes at best. *Residents were not always given care at that time, but would be routinely be told someone would be there shortly to help and the light was then shut off. *Commonly residents had to push their light "multiple times" before their needs were taken care of. That had been happening regularly since she had been employed at the facility.</p> <p>Interview on 9/10/14 at 2:00 p.m. with registered nurse (RN) A regarding residents on the east wing revealed she: *Agreed the provider's and the hospice care plans were not updated or specific for staff to know how to care for residents. *Stated staff had not been repositioning residents by schedule or according to their current needs because they were understaffed. *Stated she had not performed any new interventions for resident 12 since the new unstageable pressure ulcers had been found that morning. "I just don't have time." *Stated "His (resident 12's) [pressure ulcer] will be worse by tomorrow I'm sure. We just don't have the staff or the time." *Stated residents who were dependent on staff for hydration had not been getting fluids between meals as staffing was poor. *Stated bedtime snacks were routinely not given or residents were often sleeping when staff had been offering them, which had been related to the</p>	F 353			

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F 353	Continued From page 159 lack of staff available. *Agreed more staff was needed in the facility and had been for a "very long time." *Stated she was doing her best but felt she "had no time." *Stated the monthly MDS assessments had not been getting filled out correctly as nursing staff had little extra time being short staffed so they had been completing them often "without looking at the residents."	F 353			
F 356 SS=C	Refer to F314 findings 1, 2, and 3. <b>483.30(e) POSTED NURSE STAFFING INFORMATION</b>  The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.  The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.  The facility must, upon oral or written request, make nurse staffing data available to the public	F 356	1. Nurse staffing data is posted at the nurses' stations for each unit. 2. Any staffing changes are updated on the nurse staffing data. A signature line has been added to the form for accessibility. 3. The nursing scheduler or designee will check the nurse staffing data daily. The Administrator or designee (Manager of Director) will randomly verify, on a daily basis for a month and then at least three times a week on a continuous basis, that the nurse staffing data is updated and accurate.	10/10/14	

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F 356	<p>Continued From page 160 for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review and interview, the provider failed to ensure the twenty-four hour nursing staff posting reflected the actual staffing that was on duty to provide the basic care needs to all ninety-three residents. Findings include:</p> <p>1. Review of random twenty-four hour nursing staff postings from 8/18/14 through 9/7/14 revealed on the following: *8/30/14, There was no documentation a twenty-four hour nursing staff posting had been completed for that day. *8/31/14, There was no documentation a twenty-four hour nursing staff posting had been completed for that day. *9/5/14, The nursing schedule reflected a medication technician (MT)/ certified nursing assistant (CNA) was scheduled to work from 2:00 p.m. to 9:00 p.m. That was not documented on the twenty-four hour nursing staff posting. The nursing schedule reflected two CNAs were to work 6:00 p.m. to 6:30 a.m. The 24 hour nursing staff posting reflected three CNAs worked from 6:00 p.m. to 6:30 a.m. *9/7/14, The nursing schedule reflected two registered nurses (RN) were scheduled to work from 6:00 p.m. to 6:30 a.m. The twenty-four hour nursing staff posting reflected two RNs were</p>	F 356			

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F 356	Continued From page 161 scheduled to work from 10:00 p.m. to 6:30 a.m. *Review of the remainder of the twenty-four hour nursing staff postings showed many discrepancies between what was documented on them and the actual nursing schedule.  Interview on 9/4/14 at 10:30 a.m. with business manager O revealed she: *Had been doing scheduling for about a month and one-half to two months. *Had been put in the position the end of July 2014 after the human resource staff person who had been doing the scheduling left. She had received minimal training for the position. *Completed the twenty-four hour nursing staff postings and hung them out on the nursing units. *Tried to document on the twenty-four hour nursing staff postings what was on the nursing schedule. It was up to the charge nurses who worked the shifts to make changes on the twenty-four hour nursing staff posting to reflect what actual staff worked and the others they worked.  Interview on 9/8/14 at 4:00 p.m. with the director of nursing regarding the twenty-four hour nursing staff postings revealed she: *Agreed there were discrepancies in the nursing schedule as to what staff actually worked and their hours on the twenty-four hour nursing staff postings. *Felt it was up to the charge nurses to make the changes on the twenty-four hour nursing staff postings so they reflected the actual staff that worked.	F 356			
F 368 SS=F	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME	F 368			

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F 368	<p>Continued From page 162</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, record review, and policy review, the provider failed to: *Ensure bedtime snacks were offered to all residents consistently. *Ensure one of one resident (13) ate within fourteen hours of the evening meal. Findings include:</p> <p>1. Group interview with ten residents who preferred to remain anonymous on 9/3/14 at 11:00 a.m. revealed: **"A snack cart comes out but nobody passes it." *A snack cart was wheeled out of the kitchen nightly and placed at the nurses station. *Occasionally a nurse would wheel the bedtime snacks through the halls and pass snacks, but that was not routinely done.</p>	F 368	<p>1. Clinical record review for Resident 13 determined the resident had no negative outcome related to not receiving evening snacks. All residents who are at risk for weight loss and/or are dependent on staff for hydration were reviewed to determine no negative outcomes related to the lack of evening snacks.</p> <p>2. Evening snacks, for all residents, will be distributed to the nurses' stations by the dietary department no later than 7:30, and nursing staff will distribute to residents at that time or no later than 8:00 pm. Nursing and dietary staff were educated on the snack cart procedure. The consultant Registered Dietitian will review the records for all residents who are at risk for weight loss and/or dependent on staff for hydration and will report any issues at the weekly Wound and Weight committee meeting.</p> <p>3. At monthly QAPI meetings,</p>	10/10/14	

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F 368	<p>Continued From page 163</p> <p>*Most evenings the snack cart remained at the nurses station.</p> <p>*If the residents could get to the snack cart on their own they could have the snack.</p> <p>*if one male resident hollered loud enough the staff would bring him a snack.</p> <p>Surveyor: 32331</p> <p>2. Interview on 9/3/14 at 6:00 p.m. with the certified dietary manager (CDM) in the kitchen regarding the bedtime snack carts revealed:</p> <p>*The carts were set-up by dietary staff each evening after the supper meal.</p> <p>*There were three carts with snacks for the following areas:</p> <ul style="list-style-type: none"> <li>-East hall.</li> <li>-Warren (rehabilitation) hall.</li> <li>-Center hall.</li> </ul> <p>*Each of those snack carts were placed at the nurses station on each hall.</p> <p>*The memory care unit had been stocked with snacks to use throughout the evening as needed.</p> <p>*Those extra snacks each evening included the following:</p> <ul style="list-style-type: none"> <li>-Three sandwiches.</li> <li>-Two fruit cups.</li> <li>-Two ice creams cups.</li> <li>-Two applesauce cups.</li> </ul> <p>*There were extra snacks in addition to the snack cart sent to the Warren hall each evening that included the following:</p> <ul style="list-style-type: none"> <li>-Three sandwiches.</li> <li>-One apple.</li> <li>-Two fruit cups.</li> </ul> <p>*There were two scheduled residents, 2 and 4, that received a specific bedtime snack.</p> <p>*The nursing department was responsible for offering the snacks to the residents at bedtime.</p>	F 368	<p>the Director of Nursing and consultant Registered Dietitian will provide a collaborative report about effectiveness of the education and collaborative accountabilities for the evening snack distribution process. Based on report, further education and/ or corrective action will be planned and carried out. These reports will occur until the QAPI committee determines otherwise.</p>		

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F 368	<p>Continued From page 164</p> <p>Surveyor 33265 3. Observations on 9/5/14 from 9:00 p.m. through 10:00 p.m., 9/6/14 from 11:10 p.m. through 9/7/14 at 12:10 a.m., and 9/7/14 from 7:45 p.m. through 8:45 p.m. revealed: *Food carts with the evening/bedtime snacks sitting in ice/water were located at the center and east wings nurses station each evening. *Residents who were able to move on their own had been able to pick up an evening/bedtime snacks. *No staff member were observed making rounds with the evening/bedtime snack cart to the residents in their rooms who were unable to move on their own. *Food carts with evening/bedtime snacks remained out throughout observation times. -No ice remained in the food storage bins holding the evening/bedtime snack carts at the 11:45 p.m. observation on 9/6/14. *The administrator transported the snack cart to east wing at 8:20 p.m. on 9/7/14. Only three residents on the east wing were awake at that time, two at the nurses station and one in the dining room.</p> <p>Surveyor: 33488 4. Observations on 9/8/14 and on 9/9/14 of resident 13 during the supper and breakfast meals revealed: *She had eaten supper on 9/8/14 at 5:15 p.m. *She had eaten breakfast the next day, 9/9/14, at 9:50 a.m. *There had been no documentation on 9/8/14 the resident was given or had been offered a bedtime snack. *The total time between eating had been sixteen hours and thirty-five minutes.</p>	F 368		

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F 368	Continued From page 165 Review of the medical record for resident 13 revealed: *She had a diagnosis of dementia. *She relied completely on staff for nutrition and hydration. Refer to F314, finding 1. Surveyor 32331 5. Interview on 9/8/14 at 3:22 p.m. with the CDM regarding the residents being offered a bedtime snack revealed: *She agreed all residents on oral diets needed to have been offered a bedtime snack. *The bedtime snacks were delivered around 7:30 p.m. each evening by the dietary department. *The nursing department was responsible for offering the bedtime snacks.  Interview on 9/9/14 at 2:30 p.m. with the consultant registered dietitian regarding residents being offered a bedtime snack revealed: *Her expectation was all residents on oral diets were to have been offered a bedtime snack. *The dietary department was responsible for preparing the bedtime snacks. *The nursing department was responsible for offering the bedtime snacks.  Review of the provider's 9/4/14 Frequency of Meal Service policy revealed: *Snacks were available at any time per resident request. *The HS (bedtime) snack carts were passed between 7:30 p.m. through 8:00 p.m. to all residents. Surveyor: 33265	F 368			
F 371	Surveyor: 33488 483.35(i) FOOD PROCURE,	F 371			

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F 371 SS=E	Continued From page 166 <b>STORE/PREPARE/SERVE - SANITARY</b>  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: 32331 Based on observation, interview, testing, product information sheet review, and policy review, the provider failed to: *Maintain proper cold food temperatures for one of two meal observations and during a random observation of the afternoon snack cart (center hall nurses station). *Maintain proper sanitizing of the wiping cloths during two of two meal observations and during a random observation of the dining room (center). *Identify the date and time of the tube feeding formulas for two of two residents (9 and 14) on tube feedings. Findings include:  1. Observation on 9/2/14 at 6:20 p.m. by the center hall nurses station was a three-tiered cart that contained unopened eight-ounce milk cartons, unopened pudding packs, fruit, and packaged snacks.  Observation, testing, and interview on 9/2/14 at the above time with the certified dietary manager	F 371	See F322 related to tube feeding. 1. Temperature testing determined that cold food items were maintained at 40 degrees or colder and observation of the sanitizing solution and cloths determined they were properly used and sanitized. 2. Cold storage bins were ordered and will be used to keep food items cold while in transport and during meal service. Re-educate dietary staff on proper sanitation procedures and the procedures to maintain cold food items at 40 degrees or colder. The Dietary Manager or designee will be educated on and responsible for conducting daily kitchen inspections for one month, and will continue with daily kitchen inspections until compliance with kitchen sanitation procedures are identified as consistently followed. 3. At monthly QAPI meetings, the Dietary Manager and/or consultant Registered Dietitian will provide a report, on a continuous basis,	10/10/14	

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F 371	<p>Continued From page 167</p> <p>(CDM) in the kitchen with an eight-ounce carton of milk obtained from the above revealed: *The provider's digital food thermometer used by the CDM tested the milk at 45.5 degrees Fahrenheit (F). *The temperature of the cold food items should have been no more than 41 degrees F.</p> <p>Observation on 9/3/14 at 11:32 a.m. with dietary assistant V in the kitchen revealed: *She placed eight-ounce cartons of milk on the residents' meal trays for the memory care unit. *Those trays were inside an uninsulated aluminum cart.</p> <p>Observation on 9/3/14 at 11:50 a.m. with dietary assistant V in the same location as the above revealed: *Upon this surveyor's request one of the milk cartons on those trays was tested by dietary assistant V with the provider's digital food thermometer. -The milk was at 54.3 degrees F. *That milk carton had been in the cart for a total of eighteen minutes without a cooling source. *The temperature of the cold food items should have been no more than 41 degrees F.</p> <p>Interview on 9/3/14 at 11:50 a.m. with the CDM regarding the above milk temperature revealed: *The cold food items needed to be chilled or replaced until acceptable temperatures were obtained before serving them to the residents. *The food thermometers had been calibrated (checked for accuracy) weekly. *The temperature of the cold food items should have been no more than 41 degrees F.</p> <p>Interview on 9/9/14 at 4:10 p.m. with the CDM</p>	F 371	<p>about the effectiveness of the education on kitchen sanitation procedures based on the findings from the daily kitchen inspections. Based on the report, further education and/or correction action will be planned and carried out.</p>		

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F 371	<p>Continued From page 168 regarding the milk temperatures revealed they needed to have been at least 41 degrees F or colder for serving to the residents.</p> <p>Review of the provider's 7/16/14 Food Temperature Control policy revealed cold foods would have been held at or below 40 degrees F. They would be served promptly after being removed from the holding device.</p> <p>2. Observation on 9/3/14 from 11:37 a.m. through 12:50 p.m. with dietary assistant U with a beverage cart in the dining room revealed: *At 11:37 a.m. she had pushed the cart from the kitchen into the dining room. *There was a wet cloth on the top shelf of that cart. *That cloth was located next to: -An open silverware container holding plastic spoons. -A container that held creamer, sugar packets, and hot cocoa packets. -Pitchers of juice and a coffee pot. *At 12:05 p.m. she removed the wet cloth from on top of the cart and: -Wiped the dining room counter next to the hand sink. -Wiped up liquid spills on top of the cart. -Placed that same cloth back on top of the cart. *At 12:42 p.m. she pushed that same cart back into the kitchen. *At 12:47 p.m. she took that same cloth and wiped off the coffee pots and the top part of the cart. *At 12:50 p.m. she placed the cloth in the sanitizing solution in a red bucket next to the three compartment sink. *That wet cloth had been on the top of the beverage cart for at least one hour and thirteen</p>	F 371		

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F 371	<p>Continued From page 169 minutes.</p> <p>*At no time during the above observation was the cloth placed in the sanitizing solution.</p> <p>Observation and testing on 9/3/14 at 11:40 a.m. in the kitchen by the three compartment sink revealed:</p> <p>*A red bucket containing a clear liquid. *That bucket contained no wet cloths. *The liquid in that bucket was tested with a pH testing paper (a testing strip) and the solution tested at two hundred parts per million (ppm). *That solution would have been effective at no less than one-hundred fifty ppm. *There were no cloths that had been placed in the solution.</p> <p>Observation on 9/3/14 from 5:40 p.m. through 5:58 p.m. with dietary assistant U in the center dining room with a beverage cart revealed:</p> <p>*A wet cloth on the top of the cart. *At 5:58 p.m. she pushed the cart into the kitchen. *She then wiped down the beverage cart with that same wet cloth. *That wet cloth had been on top of the beverage cart for at least eighteen minutes. *She then put the cloth into the sanitizing solution in a red bucket on the counter next to the three-compartment sink. *The wet cloth had been on top of the beverage cart for at least eighteen minutes. *At no time during the above observation was the cloth placed in the sanitizing solution.</p> <p>Observation on 9/8/14 at 5:40 p.m. with dietary assistant U in the center dining room with a beverage cart revealed a wet cloth on top of the cart.</p>	F 371			

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F 371	Continued From page 170  Interview on 9/9/14 at 10:35 a.m. with the consultant registered dietitian (RD) and with the CDM at 4:10 p.m. regarding the wet cloths revealed they agreed the wet cloths were to have been placed in sanitizing solution when not in use.  Review of the provider's product information sheet for the Shurguard Ultimate sanitizer used in the kitchen revealed: *The sanitizer was effective at 150 through 400 ppm. *The solution was to have been applied to pre-cleaned hard surfaces, thoroughly wetting surfaces with a cloth. *The surfaces were to have remained wet for one minute followed by adequate drying. *The solution was to have been at no less than one-hundred fifty to four hundred ppm for an acceptable range for sanitizing.  Review of the provider's 7/16/14 Cleaning and Sanitation policy revealed: *The food preparation and serving areas were to have been cleaned and sanitized on a regular basis throughout the food preparation and serving process. *Sanitizing killed harmful bacteria and microorganisms. *Wiping cloths were to have been always available to have wiped down equipment and spills. *Wiping cloths were to have been cleaned, rinsed frequently in a sanitizing solution, and stored in sanitizing solution between uses.  Surveyor: 33265 3a. Observation on 9/3/14 from 5:15 p.m. through	F 371			

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F 371	<p>Continued From page 171</p> <p>5:30 p.m. of resident 9 revealed the feeding formula container was not dated or timed when opened.</p> <p>Interview on 9/3/14 at 5:37 p.m. with registered nurse B revealed she was not sure the date or time that formula container had been hung or the date the tubing was first used.</p> <p>Surveyor: 32331</p> <p>b. Observation on 9/8/14 at 1:30 p.m. in resident 14's room next to the resident's chair revealed: *A 1000 cc ready-to-hang prefilled tube feeding container of Jevity 1.2 (a tube feeding formula). *That container was turned over and suspended, using the hanging feature on the bottom of the container, and attached to an IV pole. *That container had none of the following: -Resident name. -Room number. -Date. -Start time. -Rate of the feeding.</p> <p>Review of the 2008 Ready-To-Hang Suggested Setup Procedure product information sheet for the manufacturer's prefilled tube feeding container revealed the following: *Fill in information on label with: -Patient (resident) name. -Room. -Date. -Start time. -Rate. -Proper identification and dating were essential for patient (resident) safety.</p> <p>Interview on 9/9/14 at 10:35 a.m. with the consultant RD regarding the tube feeding</p>	F 371			

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F 371	Continued From page 172 container revealed: *She had stated that once the container had been opened it needed to have been dated and timed when opened. *Her expectation was this was to have been done each time a feeding had been started.  Interview on 9/10/14 at 8:15 a.m. with the director of nursing regarding the tube feeding container revealed: *It was a standard of care to consistently have written the following: *Name of the resident. *The date. *The start time of the feeding. *That was to have been done on each bottle of tube feeding formula.  Interview on 9/9/14 at 3:15 p.m. with the consultant RD and the CDM regarding the dating and time of the tube feeding formula revealed: *The tube feeding formula was considered a food item. *The food items needed to be have been dated and labeled when opened.  Review of the provider's 7/16/14 Food Storage policy revealed: *Proper food storage was important for a safe and sanitary food service. *Foods that had been prepared would have been dated and labeled. Surveyor: 33265	F 371			
F 385 SS=G	483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN  A physician must personally approve in writing a recommendation that an individual be admitted to	F 385			

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F 385	<p>Continued From page 173 a facility. Each resident must remain under the care of a physician.</p> <p>The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on observation, interview, and record review, the provider failed to ensure a primary care physician (I) had appropriately assessed, documented, and intervened for one of one sampled resident (3) who had an ongoing serious skin issue. Findings include:</p> <p>1. Observation and interview on 9/3/14 at 9:15 a.m. with resident 3 revealed: *He was unshaven and had dried greenish nasal drainage in his mustache. *He looked as though he had not had a haircut for several months. His hair was quite long and unkept. *His scalp was reddened and had a large amount of dry scaling skin noted. The dry skin was layered and thick on his scalp. *Both ears were very pink, had scabbed areas on the lobes of the ears, and were scaling and dry. *The back of his neck was quite pink and had dry scaly skin. *He was hard of hearing. *He stated his scalp, ears, and neck were "itchy." *He was uncertain as to how long he had that scaling and dryness to those areas.</p>	F 385	<p>1. Observation and review of the clinical record for Resident 3 determined the scalp condition is improving with no further negative outcome. Clinical records for all residents with skin conditions or any significant change in condition were reviewed to ensure the primary physician was notified and has addressed the issues.</p> <p>2. Licensed nurses will be educated to report lack of physician action to the Director of Nursing. The Director of Nursing will report those concerns to the facility Medical Director for follow-up with the physician. Timeliness of reporting to the Medical Director and follow-up with the physician will be based on the acuity of the condition.</p> <p>3. At monthly QAPI meeting, the Director of Nursing will report, on a continuous basis, any issues regarding changes of condition of residents not addressed by the primary physician.</p>	10/10/14	

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F 385	<p>Continued From page 174</p> <p>Interview on 9/3/14 at 10:20 a.m. with registered nurse (RN) B regarding resident 3's skin issues revealed:</p> <p>*She stated "He is a mess." *He had the skin issues to the scalp, neck, and ears since 7/10/14. *His primary physician had seen him on 8/26/14 but had not addressed his skin issues. *There was a dermatology appointment made for September 16 through the Veteran's Administration (VA). *There had been no treatment ordered after the skin issues had been identified. *She was unsure as to the reason there had been no treatments attempted prior to his dermatology appointment.</p> <p>Review of resident 3's physician's progress notes and physician's orders from July 2014 to September 3, 2014 revealed physician I had not documented any information regarding the resident's skin issues on his scalp, back of his neck, or his ears</p> <p>Telephone interview on 9/3/14 at 10:30 a.m. with VA community care coordinator G and RN H regarding resident 3 revealed: *He had a dermatology appointment scheduled for September 16 by telemedicine. *He had been seen on 7/3/13 at the VA. The provider called the VA on 7/11/14, and that was when the dermatology appointment had been scheduled. *They both were unsure as to the reason there had been no medical treatment provided for resident 3's skin condition.</p> <p>Interview on 9/3/14 at 11:15 a.m. with licensed social worker F regarding resident 3's skin</p>	F 385			

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F 385	<p>Continued From page 175 concerns revealed:</p> <ul style="list-style-type: none"> <li>*He was typically unshaven. That's who he was.</li> <li>*He had refused care at times:</li> <li>*She was unaware his scalp, neck, and ears were that bad.</li> <li>*She would have expected the nurses to intervene for his skin condition.</li> <li>*She agreed the primary care physician should have been involved with the immediate care of his scalp.</li> </ul> <p>Observation on 9/3/14 at 12:25 p.m. of resident 3 at the Center dining room table revealed as he was eating his noon meal he kept scratching his scalp, ears, and face. He only ate approximately 10 percent of his noon meal. Then got up from the table and left the dining room.</p> <p>Interview on 9/3/14 at 3:40 p.m. with RN B regarding resident 3 revealed:</p> <ul style="list-style-type: none"> <li>*There had been no medical intervention for his scalp, neck, and ears skin issues.</li> <li>*The VA had been contacted on 7/10/14.</li> </ul> <p>Interview and observation on 9/3/14 at 3:50 p.m. with the director of nursing (DON) in resident 3's room revealed:</p> <ul style="list-style-type: none"> <li>*She was unaware of his skin issues.</li> <li>*She agreed the skin issues were severe.</li> <li>*She agreed there should have been some medical treatment intervention from the primary physician or the VA prior to his dermatology appointment on September 16, 2014.</li> </ul> <p>Telephone interview on 9/3/14 at 4:55 p.m. with primary care physician I regarding resident 3 revealed he:</p> <ul style="list-style-type: none"> <li>*Had not felt the resident's skin condition was an emergency.</li> </ul>	F 385		

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F 385	Continued From page 176 *Stated, "I don't know what to do with him." *Had the skin condition for a few months. *Felt the resident was "lucky" to have had an appointment with the VA dermatology.  Interview and observation on 9/4/14 at 9:45 a.m. with the medical director in resident 3's room regarding his skin issue revealed: *He was unaware the skin issue was acute. He thought it looked like a chronic condition. *He agreed the skin condition should have had medical treatment intervention by the primary physician before the scheduled dermatology appointment.  There was no policy provided from the director of nursing addressing the responsibility of the primary care physician.  Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 278, revealed: *"Nurse/physician collaborative practice. Collaboration is a process between individuals. There is a sharing of different perspectives that are then synthesized to better understand complex problems. An outcome of collaboration is a shared solution that could not have been accomplished by a single person or organization. Nurse-physician collaboration improves patient safety and outcomes and reduces errors."	F 385			
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit	F 425			

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F 425	<p>Continued From page 177</p> <p>unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to ensure mood/behavior and narcotic pain medications were assessed and documented for their effectiveness for seven of seven sampled residents (13, 32, 33, 34, 38, 43, and 45). Findings include:</p> <p>1. Review of resident 13's 5/17/14 through 7/23/14 as needed (PRN) record revealed: *Roxanol (narcotic pain medication) and lorazepam (anti-anxiety medication) had been administered two times for crying and generalized pain. *There was no follow-up documentation as to the effectiveness of the Roxanol or lorazepam for those two doses.</p>	F 425	<p>1. Review of the clinical records for Residents 13, 32, 33, 34, 38, 43 and 45 determined the residents had no negative outcome related to not assessing the effectiveness of the as needed (PRN) medications. The antipsychotic and pain monitoring tools for all residents in September 2014 were reviewed for documentation gaps related to assessing the effectiveness of the PRN medications.</p> <p>2. The Medical Records Coordinator will review the antipsychotic and pain monitoring tools for documentation gaps for all residents for October 2014, and then random audits for 20% of the MARs for 90 days. Identified lack of assessing effectiveness will be reported to the Director of Nursing. When system is determined to be in place, the audits will be discontinued. The consultant pharmacist will educate nursing staff on the policy and procedures related to assessing the effectiveness of PRN medications.</p>	10/10/14	

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F 425	<p>Continued From page 178</p> <p>2. Review of resident 32's 5/20/14 through 7/9/14 PRN record revealed: *Ativan (anti-anxiety medication) had been administered three times for yelling, agitated, and combative behavior. *One of the doses of Ativan had no documentation as to the effectiveness of it.</p> <p>3. Review of resident 33's 6/15/14 through 8/8/14 PRN record revealed: *Tramadol (narcotic pain medication) had been administered five times with no follow-up documentation as to the effectiveness of it for one of the doses. *Hydrocodone (narcotic pain medication) had been administered eight times with no follow-up documentation as to the effectiveness for four of the doses.</p> <p>4. Review of resident 34's 7/28/14 through 8/3/14 PRN record revealed: *Oxycodone (narcotic pain medication) had been administered eleven times. *There was no follow-up documentation as to the effectiveness of it for three doses.</p> <p>5. Review of resident 38's 6/14/14 through 9/2/14 PRN record revealed: *Ativan had been administered nine times for agitated and resistive behavior. *There was no follow-up documentation as to the effectiveness of it for two of the doses.</p> <p>6. Review of resident 43's August 2014 PRN record revealed Tramadol had been administered one time with no follow-up documentation as to the effectiveness of it.</p> <p>7. Review of resident 45's 8/25/14 through 9/3/14</p>	F 425	<p>3. At the monthly QAPI meeting, the Director of Nursing will provide a report about the effectiveness of the education based on the review of the monitoring tool audits. These reports will occur until the QAPI committee determines otherwise.</p>		

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F 425	<p>Continued From page 179</p> <p>PRN record revealed:</p> <ul style="list-style-type: none"> <li>*Hydromorphone (narcotic pain medication) had been administered thirty-seven times.</li> <li>*There was no follow-up documentation as to the effectiveness of it for ten of the doses.</li> <li>*There was no documentation the physician had been contacted regarding frequent PRN usage of the Hydromorphone and the possibility of getting it scheduled routinely.</li> </ul> <p>8. Interview on 9/10/14 at 10:00 a.m. with the director of nursing (DON) regarding PRN usage revealed she:</p> <ul style="list-style-type: none"> <li>*Had only been at the facility for about three weeks.</li> <li>*Was not going to state what her expectations of PRN follow-up was because the nurses did not even know yet.</li> </ul> <p>Review of the provider's June 2014 General Medication Administration policy revealed:</p> <ul style="list-style-type: none"> <li>**"If a PRN medication is administered, nursing shall document on the back of the medication administration record (MAR). Include the date, time, medication, reason for administering, and initials."</li> <li>**"In addition, nursing shall document the results of the PRN medication on the MAR."</li> </ul> <p>Review of the provider's 10/23/13 Medication Therapy and Administration policy revealed:</p> <ul style="list-style-type: none"> <li>**"The DON will supervise and direct all nursing personnel who administer medications and/or have related functions."</li> <li>**"If a resident uses PRN medications frequently, the attending physician and interdisciplinary care team, with support from the consultant pharmacist as needed, shall reevaluate the situation and examine the individual as needed."</li> </ul>	F 425			

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F 425	Continued From page 180 **"The team will determine if there is a clinical reason for the frequent PRN use, and consider whether a standing dose of medication is clinically indicated."	F 425		
F 428 SS=C	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.  This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on record review, interview, and policy review, the provider failed to ensure monthly pharmacy consultations (consult) for sixteen of sixteen sampled residents (1, 2, 3, 4, ,5 ,6, 7, 8, 9, 10, 11, 12, 13, 14, 15, and 16) were signed by the consulting pharmacist. Findings include:  1. Review of all sixteen sampled residents mentioned above had monthly pharmacy consults. However the consultations were not appropriately signed by the consulting pharmacist.  Telephone interview on 9/9/14 at 9:55 a.m. with pharmacist M regarding resident pharmacy consults revealed the consulting pharmacist	F 428	1. The consultant pharmacy company was requested to send a consultant pharmacist to sign the drug regimen review documentation for Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 and 16. 2. The consultant pharmacy company will be contacted if future drug regimen reviews do not have signatures. 3. The Director of Nursing will review monthly drug regimen reviews for signature and will provide a report during the monthly QAPI meeting. These reports will occur until the QAPI committee determines otherwise.	10/10/14

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F 428	Continued From page 181 usually stamped their name on the monthly consults.  Telephone interview on 9/9/14 at 10:00 a.m. with pharmacist N regarding the signatures of the pharmacists on the monthly consultations revealed: *He was the consulting pharmacist for the provider. *He only signed those consults that required no follow-up or medication changes. **"See Facility Records" typed on the monthly pharmacy consults meant to look at previous consultations for his signature. *He had stated there were just too many consults to stamp or sign all them. *He was unsure what his company's policies were in signing of the monthly consultation reports.  Review of the provider's April 2007 Pharmacy Services-Role of the Consultant Pharmacist policy revealed "A documented review of the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines."	F 428			
F 431 SS=F	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.	F 431	1. There was no negative outcome related to reconciliation of controlled medications for Residents 10, 17, 24, 28, 31, 49, 50, 51, 52, 53, 54, 55, 56 and 57. 2. Only the nurses and medication technicians have keys to the locks for the medication rooms and the lock boxes.	10/10/14	

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F 431	<p>Continued From page 182</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to: *Ensure a system was in place to account for controlled medications awaiting destruction or brought from home by residents for 14 of 14 sampled residents (10, 17, 24, 28, 31, 49, 50, 51, 52, 53, 54, 55, 56, and 57). *Ensure medication refrigerator temperatures were monitored and documented consistently for two of three medication refrigerators (center and east).</p>	F 431	<p>Medications brought in from home for short-term residents will be labeled and locked in the medication room; for long-term residents, the medications will be sent home with the family or responsible party. The Director of Nursing carries the narcotics key for the narcotics waiting for destruction. The consultant pharmacist and the Director of Nursing are destroying narcotics monthly. The night nurse, every week, will check the medication carts and medication refrigerator and for any medications that have not been destroyed, picked up, or taken home.</p> <p>3. The Director of Nursing will report, on a continuous basis, during the monthly QAPI meeting on any issues related to reconciliation and destruction of controlled medications.</p>	

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F 431	<p>Continued From page 183</p> <p>*Destroy non-controlled medications in a timely manner in three of four medication rooms (Warren, east, and center).</p> <p>*Ensure the medication cart and narcotic keys were not accessible to unauthorized individuals in four of four medication rooms (Warren, memory care, east, and center).</p> <p>*Ensure documentation of the destruction of controlled medications upon discharge for two of two sampled residents (19 and 31). Findings include:</p> <p>1. Observation on 9/9/14 at 10:00 a.m. of the Warren medication room revealed: *A sack that contained multiple bottles of medications brought from home by resident 28. -The sack contained a bottle of hydrocodone (controlled narcotic pain medication) with twenty-four tablets. -The sack contained an empty bottle of lorazepam (controlled anti-anxiety medication). -There was no documentation of the amounts of hydrocodone or lorazepam the resident had brought into the facility. *There was a locked cabinet that was opened with a key by the director of nursing (DON). The box contained multiple controlled medication cards and bottles awaiting destruction that did not have a narcotic count record for the following residents: -Resident 53- Vimpat (anti-convulsant medication) twenty-seven pills and two vials (bottles) of diazepam (anti-anxiety medication). -Resident 54- Phenobarbital (anti-convulsant medication) thirty-three pills and Androderm (testosterone) twenty-one patches. *There was an unlocked black box next to the copier machine in the Warren wing nurses' station. There were multiple keys in the black box</p>	F 431			

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F 431	<p>Continued From page 184 including a key to the medication cart and the narcotic box.</p> <p>Interview at that time with registered nurse (RN) OO regarding resident 28's medications brought from home revealed: *She was unsure what they did with medications brought from home by a resident. *The sack of medications had been there for awhile. *They did not count any narcotic medications brought from home by a resident. *The controlled medications should have probably had a narcotic count sheet made out, or the medications should have been sent back home with the family.</p> <p>2. Observation on 9/9/14 at 10:20 a.m. of the center medication room revealed: *A large amount of ice buildup in the freezer compartment of the medication refrigerator. *There were multiple daily medication refrigerator temperatures not documented on the July 2014 through September 2014 records. *There was no documentation the weekly medication refrigerator cleaning had been completed on the July 2014 through September records. *There was a large cardboard box sitting on the floor that contained multiple medication bottles for multiple residents. Many of the bottles had a sticky residue on them and were stuck to the bottom of the box. *There were two key rings that contained a large number of keys hanging on a hook. There were three single keys laying on the medication counter. *There was a locked cabinet that was opened with a key by the director of nursing (DON). The</p>	F 431			

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F 431	<p>Continued From page 185</p> <p>box contained multiple controlled medication cards and bottles awaiting destruction that did not have a narcotic count record for the following residents:</p> <ul style="list-style-type: none"> <li>-Resident 49- Lorazepam (anti-anxiety medication) twenty-eight pills.</li> <li>-Resident 50- Hydrocodone (narcotic pain medication) sixty-one pills.</li> <li>-Resident 51- Diphenoxylate atropine (anti-diarrheal medication) four pills.</li> <li>-Resident 52- An opened bottle of lorazepam liquid.</li> </ul> <p>3. Observation on 9/9/14 at 11:00 a.m. of the east medication room revealed:</p> <ul style="list-style-type: none"> <li>*A large amount of ice buildup in the freezer compartment of the medication refrigerator.</li> <li>*There were multiple daily medication refrigerator temperatures not documented on the July 2014 through September 2014 records.</li> <li>*There was no documentation the weekly medication refrigerator cleaning had been completed on the July 2014 through September 2014 records.</li> <li>*There was a large bottle of instant food thickener in the medication refrigerator with an opened date of 6/4/14. The label on the back of the thickener box stated the contents expired ninety days after being opened.</li> <li>*There was a sack on the counter that contained a bottle of Lyrica (controlled seizure medication) that resident 57 had brought from home. There was no documentation of how much Lyrica had been brought into the facility.</li> <li>*There was a locked cabinet that was opened with a key by the DON. The cabinet contained multiple controlled medication cards and bottles awaiting destruction that did not have a narcotic count sheet.</li> </ul>	F 431			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/11/2014
NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105		
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F 431	<p>Continued From page 186</p> <ul style="list-style-type: none"> <li>-Resident 10- An opened bottle of lorazepam liquid.</li> <li>-Resident 24- Hydrocodone twenty-nine pills.</li> <li>-Resident 55- Tramadol (narcotic pain medication) seventeen one-half pills.</li> <li>-Resident 56- Tramadol fifty pills and an opened bottle of morphine solution (narcotic pain medication) 20 milliliters.</li> <li>-Resident 57- Lyrica thirty-four pills.</li> </ul> <p>4. Review of resident 17's medical record revealed: *He had expired on 8/22/14. *There was no documentation of the destruction or narcotic record sheet for sixty hydrocodone pills.</p> <p>5. Interview on 9/9/14 at 12:15 p.m. with the DON regarding the above revealed: *The medication refrigerator temperatures and weekly cleaning should have been documented. *She had only started three weeks ago and did not know why the sacks and boxes of medications were in the medication rooms awaiting destruction. *The consultant pharmacist had destroyed controlled medications with the previous DON the first part of August 2014. He had come on 9/3/14, but it had been determined since the surveyors were in the facility he would return the week of 9/16/14 to destroy medications. *She did not know why the narcotic records were missing from the above medications. The expectation was the nurses would put the medication card/bottle through the opening in the top of the locked cabinets with the narcotic record with them. *She was able to locate some other missing narcotic records filed in the residents' charts, but</p>	F 431		

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F 431	<p>Continued From page 187</p> <p>all of the above appeared to be missing. *She did not know why so many keys were on key rings and lying around on the medication counters. Her key ring also had many keys she did not know what they belonged to. *She was not aware of the unlocked box next to the copier machine in the Warren wing nurses station that had multiple keys in it including the medication cart key and narcotic key. It was unknown whether the box also contained keys to other medication carts and narcotic boxes.</p> <p>Review of the provider's 10/28/13 Medications Brought to the Facility by the Resident/Family policy revealed: **If a medication is not otherwise available and/or it is determined to be essential to the resident's life, health, safety, or well-being to be able to take a medication brought in from the outside, the DON and nursing staff, with support of the attending physician and consultant pharmacist shall check to ensure: -State law and regulations allow such use. -The medications have been ordered by the resident's attending physician, and documented on the physician's order sheet. -The contents of each container are labeled in accordance with established policies. -The contents of each container have been verified by a licensed pharmacist." **Non-prescription medications in sealed containers and/or medications received directly from a transferring facility may be administered without further verification." **Medications brought into the facility that are not approved for the resident's use shall be returned to the family. If the family does not pick them up within 30 days, the facility may destroy them in accordance with established policies."</p>	F 431		

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F 431	<p>Continued From page 188</p> <p>Review of the provider's 10/28/13 Controlled Substance policy revealed: **All keys to controlled substance containers shall be on a single key ring that is different from any other keys." **The charge nurse on duty will maintain the keys to controlled substance containers. The DON will maintain a set of back-up keys for all medication storage areas including keys to controlled substance containers."</p> <p>Review of the provider's 10/28/13 Discarding and Destroying Medications policy revealed "All unused controlled substances shall be retained in a securely locked area with restricted access until disposed of."</p> <p>Review of the provider's April 2011 Discontinued, Unused, or Expired Medication policy revealed: **Controlled substances shall be destroyed by the consultant pharmacist in conjunction with the DON." **A notation will be made on each resident's Drug Disposition record, or in the medical record for each controlled substance destroyed, including date, prescription number, name and strength of medication, quantity, and method of destruction." **A notation will be made in the Narcotic Log Book indicating quantity of medication destroyed, date, and method of destruction." **Each controlled substance destroyed will be recorded on the Certificate of Inventory and Destruction for Controlled Substances." **A copy of this certificate will be kept on file in the facility for at least two years."</p> <p>Review of the provider's 2/12 Controlled Substance Handling policy and procedure</p>	F 431			

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F 431	<p>Continued From page 189</p> <p>revealed:</p> <p>**"Drugs maintained in the facility that are listed as schedule II-V Controlled Substances shall require special handling, storage, disposal, and record keeping."</p> <p>**"There shall be an individual narcotic record on which a complete record of receipt and withdrawal of controlled substances for an individual resident is maintained."</p> <p>**"Only authorized staff shall have access to medications, including controlled substances maintained within the facility."</p> <p>**"Controlled substances must be counted upon delivery."</p> <p>Surveyor: 32332</p> <p>6a. Observation on 9/10/14 from 9:00 a.m. through 9:50 a.m. of the nurse's station on the Warren unit revealed an unlocked key holder box attached to the wall above the copier machine. Inside the box contained multiple keys including:</p> <p>*A key marked Warren Narcotics.</p> <p>*A key marked Warren Medication Cart.</p> <p>Review of resident 31's closed medical record revealed:</p> <p>*He had been discharged on 9/2/14.</p> <p>*He had an 8/3/14 physician's order for Tramadol to have been given every six hours as needed.</p> <p>*One blue Individual Resident's Controlled Drug Substance Record that had indicated:</p> <p>-One card containing fifteen tablets of Tramadol had been dispensed from the pharmacy on 8/8/14.</p> <p>-All fifteen tablets had been given between 8/9/14 through 8/18/14.</p> <p>*Review of the August 2014 and September 2014 medication administration records, Pain Monitoring Tool, and Individual Resident's Controlled Substance Record had indicated</p>	F 431			

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F 431	Continued From page 190 thirty-eight tablets of Tramadol had been used; thirty-five tablets in July and three tablets in August.  Interview on 9/10/14 at 2:10 p.m. with the DON. regarding the location of the Tramadol after the resident had been discharged and their controlled substance records revealed: *She had been unable to locate any Tramadol or the controlled substance records. *She had phoned the consultant pharmacist who had dispensed the Tramadol and had been informed three cards of thirty Tramadol had been dispensed: -Thirty tablets on 8/3/14. -Thirty tablets on 8/18/14. -Thirty tablets on 9/1/14 (the day before he had been discharged). *She had not known where any of the tablets or the records had gone. *The provider had not been accountable for the controlled medications. Surveyor: 16385 b. Review of resident 19's closed medical record revealed no documentation for the disposition/destruction of the pain medication Fentanyl 25 micrograms per hour, change every seventy-two hours.  Interview on 9/9/14 at 3:00 p.m. with the director of nursing revealed she could not locate the medication destruction sheet for resident 19's Fentanyl medication. She stated she would ask the medical records person to locate the documentation. No documentation was provided up to the end of the survey on 9/11/14.	F 431			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		10/10/14	

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F 441	Continued From page 191  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.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	1. The new Staff Development Coordinator has assumed responsibility as the Infection Control Nurse. 2. The Infection Control Manual has been updated to reflect current practice. The Infection Control Nurse will be provided with an opportunity to receive instruction on current infection control practices, and will be responsible for infection control practices related to care of the residents as well as employee health. An all staff in-service on infection control practices has been scheduled for 10/24/14. 3. The Infection Control Nurse will monitor the effectiveness of the infection control practices through monthly surveillance activity as directed by the Infection Control Manual. At monthly QAPI meetings, the Infection Control Nurse will report, on a continuous basis, the occurrence of all resident infections for the previous month, and compliance with	

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F 441	<p>Continued From page 192</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on interview, and policy review, the provider failed to ensure a functional infection control program was in place. Findings include:</p> <p>1. Interview on 9/4/14 at 10:30 a.m. with the staff member identified as the infection control nurse revealed: *She had been hired as a Minimum Data Set (MDS) coordinator. *She was functioning as an MDS coordinator. *The infection control nurse position was delegated to her a few weeks ago when the former infection control nurse had left. *She had no training in infection control beyond basic training in nursing school. *She had no knowledge of any training that had been scheduled for her. *She was not sure she would be keeping the delegated infection control nurse role. *She expressed a need for training if she was to keep the delegated infection control role. *She was to handle the infection control segment for the residents only and not the employees. *She was not sure who had been assigned the infection control duties regarding employees. *She had not provided any instruction on infection control practices for general orientation to new employees. *She had no idea who would be teaching the scheduled September 2014 all staff inservice on infection control for the provider. *She had not completed any monitoring of the employees concerning infection control practices.</p> <p>Interview on 9/10/14 at 1:40 p.m. with the director of nursing revealed she believed the identified</p>	F 441	infection control practices based on surveillance activity.		

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F 441	<p>Continued From page 193</p> <p>infection control nurse was responsible for infection control practices of both the residents and the employees.</p> <p>Review of the provider's April 2013 monitoring compliance with infection control policy revealed: *The infection preventionist or designee shall monitor the effectiveness of the infection control work practices and protective equipment. That included, but was not limited to: - Surveillance of the workplace to ensure established infection control practices were observed and protective protective clothing and equipment were provided and properly used. -Investigation of known or suspected exposures to blood or body fluids. -Investigation of known or suspected transmission of healthcare-associated infections. -Improvement in training, work practices, or protective equipment to prevent infection recurrence. -Effective implementation of hand hygiene practices by all departments. -Effective implementation of disposable gloves to present the spread of infections.</p> <p>Review of the provider's 2/13/13 employee infection and vaccination status policy revealed: *The medical director and the infection control coordinator would collaborate to determine the significance of any employee health condition in relation to the job responsibilities and the employees' restrictions regarding resident contact. *Staff were to have reported any exposure to a resident's blood or body fluids to the infection control coordinator or designee as soon as practical after the exposure.</p>	F 441			

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F 441	Continued From page 194 Review of the provider's 2/13/13 employee training on infection control policy revealed the infection control coordinator and administrator would identify those disciplines or individuals who needed task or job-specific infection control training beyond that provided by initial orientation or policies and procedures.  Review of the provider's 2/13/13 employees of other employers, infection control policy revealed the infection control coordinator was responsible for informing employees of other employers of any infection control hazards they might encounter while in the work area or while on the premises.	F 441			
F 490 SS=1	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, interview, record review, and policy review, the provider failed to ensure the facility was operated and administered in a manner that attained or maintained the highest practicable physical, mental, and psychosocial well-being of all ninety-three residents. Findings include:  1. Interview on 9/9/14 at 9:00 a.m. with the administrator revealed:	F 490	1. The Administrator will direct and/or oversee the plans of correction for all system changes and QAPI audits related to tags F157, F164, F166, F204, F221, F222, F224, F225, F226, F241, F248, F252, F278, F279, F280, F281, F309, F314, F322, F323, F325, F327, F332, F333, F353, F356, F368, F371, F385, F425, F428, F431, F441, F505, F514, and F520.  2. Correction of the above-listed tags will indicate compliance with this requirement.	10/10/14	

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F 490	<p>Continued From page 195</p> <p>*He reported to the chief financial officer (CFO) any concerns or problems he had with the facility.</p> <p>*He usually informed the CFO on the phone or in e-mails of any concerns he had. He had not kept any of the e-mails he had sent to the CFO.</p> <p>*He had informed the CFO the end of July 2014 or first part of August 2014 of staffing issues. The CFO's response to him at that time had been "Figure it out with the staff you have."</p> <p>*He felt the CFO had a "bad taste" regarding the big financial bill that was run up last year from using the staffing agencies.</p> <p>**"Maybe I did a bad job explaining to him how dire we were."</p> <p>*He was told about two weeks ago when the previous director of nursing (DON) left he could use the staffing agencies.</p> <p>*He had called three staffing agencies on 8/21/14 and was told "We were too late in the game and all staff were on contract with another facility. It was going to be difficult to get us any staff. Someone that was on contract would have to cancel before we could get any staff. He had requested two day certified nursing assistants (CNA) twelve hour shifts and two night CNAs twelve hour shifts.</p> <p>*One staffing agency told them they had to establish a contract with them before they could provide staff. He had developed a contract with them on 8/26/14. Their option with that facility was only nurses as the CNAs were not certified.</p> <p>*Two staffing facilities had not been able to supply them with any staff.</p> <p>*One staffing facility had sent them a CNA on 8/27/14 and on 9/9/14. They had sent them a licensed practical nurse on 9/7/14 that they utilized as a CNA.</p> <p>*He or business manager O had called the staffing agencies every two to three days after</p>	F 490		

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F 490	Continued From page 196 8/21/14, and their response was always the same "They did not have any staff they could send us." *The second time they had called the staffing agencies they changed their request to eight hour CNAs instead of twelve hour CNAs to increase their chances of getting help.  Phone interviews on 9/9/14 at 9:30 a.m. with the three staffing agencies revealed: *None of the agencies were aware when the initial request from the facility had been for staff. *It was usually business manager O they had spoken to from the facility. *None of the agencies had documentation the facility had requested eight hour shift CNAs instead of twelve hour shift CNAs *Only one of the staffing agencies had been able to supply them any staff as the administrator had confirmed.  Interviews, observations, record reviews, and policy reviews throughout the course of the survey revealed the administration had not ensured all residents attained and/or maintained their highest practicable physical, mental, and psychosocial well-being. Refer to F157, F164, F166, F204, F221, F222, F224, F225, F226, F241, F248, F252, F278, F279, F280, F281, F309, F314, F322, F323, F325, F327, F332, F333, F353, F356, F368, F371, F385, F425, F428, F431, F441, F505, F514, and F520.	F 490			
F 493 SS=1	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN  The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the	F 493			

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F 493	<p>Continued From page 197</p> <p>management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the governing body failed to ensure the facility was administered in a manner that ensured:</p> <ul style="list-style-type: none"> <li>*Confidentiality of all ninety-three residents regarding influenza vaccinations was maintained and not stored on the Minimum Data Set door on the east hall.</li> <li>*Four of ten confidential residents' grievances regarding a staff member were resolved.</li> <li>*One of one sampled resident (31) was educated regarding skin needs upon discharge.</li> <li>*Three sampled residents (10, 14, and 16) had been assessed for the use of a physical restraint.</li> <li>*An antianxiety medication was appropriately administered to 1 of 1 sampled resident (2) to treat a medical condition instead of for staff convenience.</li> <li>*One of one sampled nursing staff (L) who had allegations of simple assault had been thoroughly investigated previous to having been hired.</li> <li>*Reference checks were completed for 8 of 9 employees (L, CC, DD, EE, FF, GG, HH, and II) prior to having been hired.</li> <li>*Allegations regarding missing money, missing jewelry, residents' bums, residents' elopements, and an unwitnessed fall with injury were investigated for six sampled residents (12, 13, 32, 33, 34, and 38).</li> </ul>	F 493	<p>1. The governing body will oversee the plans of correction for all system changes and QAPI audits related to tags F157, F164, F166, F204, F221, F222, F224, F225, F226, F241, F248, F252, F278, F279, F280, F281, F309, F314, F322, F323, F325, F327, F332, F333, F353, F356, F368, F371, F385, F425, F428, F431, F441, F505, F514, and F520.</p> <p>2. Correction of the above-listed tags will indicate compliance with this requirement.</p>	10/10/14

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F 493	<p>Continued From page 198</p> <p>*Call lights were answered in a timely manner that enhanced resident dignity and respect for 2 of 2 random residents (35 and 42).</p> <p>*Nail care was done for 3 of 16 sampled residents (1, 6, and 9).</p> <p>*One of one sampled resident (12) who was dependent on staff was assisted to eat in a timely manner.</p> <p>*Interventions were in place to communicate with 1 of 1 sampled resident (7) who had a hearing impairment.</p> <p>*Activity intervention was provided for 1 of 1 sampled resident (10) who was on isolation due to a medical condition.</p> <p>*Activities were provided and documented for 1 of 4 sampled residents (3).</p> <p>*A homelike environment was provided for all the residents on 1 of 1 memory care unit.</p> <p>*One of one sampled resident (3) who had an acute skin condition was assessed.</p> <p>*A comprehensive care plan was developed for 1 of 1 sampled resident (30).</p> <p>*Twelve of fourteen residents' care plans were updated and revised to reflect their current needs.</p> <p>*Post-hospitalization physicians' orders were clarified with the physician for 2 of 2 sampled residents (7 and 12).</p> <p>*Physician's orders were followed for 1 of 1 sampled resident (13) who was administered the antipsychotic medication Risperdal.</p> <p>*Physicians's orders for medication administration for four sampled residents (12, 16, 37, and 47) were appropriately followed.</p> <p>*Weights were consistently obtained for 1 of 1 sampled resident (15) who was on dialysis (artificial means of removing toxins from body).</p> <p>*Physicians' orders for obtaining weights was followed for 2 of 2 residents (9 and 14) who received enteral (tube into the stomach) feedings.</p>	F 493			

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F 493	<p>Continued From page 199</p> <ul style="list-style-type: none"> <li>*One of one sampled resident (3) who had an acute skin condition was assessed, monitored, and medical treatment was provided.</li> <li>*One of one sampled resident (17) who was on hospice (end of life care) was assessed and monitored for pain management.</li> <li>*The prevention or worsening of pressure ulcers did not occur from the lack of skin assessment and the lack of adequate hydration for 3 of 4 sampled residents (6, 12, and 13).</li> <li>*Outside doors were locked between the hours of 8:00 p.m. and 7:00 a.m. for resident safety for 4 of 4 sampled doors.</li> <li>*Crash carts were functioning and accessible in 2 of 3 sampled units (Warren and Center).</li> <li>*One of one sampled resident (5) on a therapeutic diet received the correct meal tray.</li> <li>*Acceptable parameters of nutritional status was maintained for 1 of 2 sampled residents (14) who received enteral feedings.</li> <li>*Sufficient hydration for 2 of 2 sampled residents (12 and 13) who were dependent on staff was provided.</li> <li>*A medication error rate of less than 5 percent (%) was met. The medication error rate was 9.5 %.</li> <li>*Four of four sampled residents (2, 40, 46, and 48) received their medications as ordered by the physician's.</li> <li>*Sufficient staff were on duty all shifts to provide basic resident care needs to all residents.</li> <li>*The nursing staff information posted daily was accurate and reflected the current schedule.</li> <li>*Bedtime snacks were offered to all residents on oral diets on a daily basis.</li> <li>*One of one sampled resident (12) received the breakfast meal within fourteen hours of the supper meal.</li> <li>*Sanitation was maintained at 2 of 2 meal</li> </ul>	F 493		

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F 493	<p>Continued From page 200</p> <p>services and at randomly observed times.</p> <p>*Milk that was served to the residents was not greater than 41 degrees Fahrenheit.</p> <p>*Seven of seven sampled residents (13, 32, 33, 34, 38, 43, and 45) who received as needed (PRN) medications for mood and behavior or pain had follow-up documentation as to the effectiveness of the medications.</p> <p>*Pharmacy consultations were signed by the consultant pharmacist for 16 of 16 sampled residents (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, and 16).</p> <p>*An active infection control program had been maintained.</p> <p>*An effective quality assurance (QA) program had been maintained to identify concerns and to develop and implement corrective action.</p> <p>*Medication destruction had been completed in a timely manner in 3 of 4 medication rooms (Warren, east, and center).</p> <p>*Medication refrigerator temperatures were consistently documented in 2 of 3 medication rooms (center and east).</p> <p>*Medication and narcotic box keys were not accessible to unauthorized staff on 1 of 3 nursing units (Warren).</p> <p>*Controlled medication accountability was maintained for 13 sampled residents (10, 17, 24, 29, 31, 34, 49, 50, 51, 52, 53, 54, and 56).</p> <p>Findings include:</p> <p>1. Interview on 9/8/14 at 11:00 a.m. with the chief financial officer regarding the above revealed:</p> <p>*He and the owner were the governing body of the facility.</p> <p>*The administrator reported to him, and he reported to the owner.</p> <p>*He was responsible for the accounting, the books, and the reporting.</p>	F 493		

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F 493	<p>Continued From page 201</p> <p>*He had recently became aware of a lot of things but primarily staffing. He was told by the administrator that staffing was "challenged." He had told the administrator and the director of nursing (DON) about two weeks ago if they had exhausted all their staff for staffing to call a staffing agency.</p> <p>*He thought it was about the third week of August the administrator had informed him of the staffing issues, and he informed the owner.</p> <p>*He would have thought the administrator would have called the staffing agency at that time.</p> <p>*He thought the last time the administrator used a staffing agency was in August 2013. The facility had occurred a large bill with the staffing agency that took them awhile to pay off.</p> <p>*He and the owner had felt any information from the administrator "had been dwindling for awhile."</p> <p>*If the administrator informed him of anything it was usually on the phone, texts, or e-mails.</p> <p>*He was not sure if had kept any of the e-mails or texts but would provide them for the surveyor if he had. No texts or e-mails were provided to the surveyor by the end of the survey on 9/11/14</p> <p>*He had usually come to the facility once a month, but the last month had come a couple of times a week.</p> <p>*He and the owner had concerns since the information provided by the administrator had been dwindling.</p> <p>*When they would ask the administrator how things were he would usually voice no concerns or that he had everything under control.</p> <p>*The facility had a lot of nursing students during the 2014 summer and had put no plan in place to replace them when they had returned to school.</p> <p>*When the previous director of nursing (DON) left about a month ago she had voiced no concerns to him.</p>	F 493			

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F 493	Continued From page 202 *The present DON had been hired to be the staff development person but had agreed to be the interim DON. *They had put cameras in the facility a couple months ago related to missing items.  Interviews, observations, record reviews, and policy reviews throughout the course of the survey from 9/2/14 through 9/11/14 revealed the governing body had not ensured the safe management and overall well-being of all ninety-three residents. Refer to F157, F164, F166, F204, F221, F222, F224, F225, F226, F241, F248, F252, F278, F279, F280, F281, F309, F314, F322, F323, F325, F327, F332, F333, F353, F356, F368, F371, F385, F425, F428, F431, F441, F505, F514, and F520.	F 493			
F 505 SS=D	<b>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS</b>  The facility must promptly notify the attending physician of the findings.  This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on record review and interview, the provider failed to report abnormal laboratory (lab) values for one of one sampled resident (3) to the primary care physician. Findings include:  1. Review of resident 3's complete medical record revealed: *On 7/3/14 he had lab drawn with the following results: -Vitamin D Total (indicates osteoporosis which can cause bone pain and muscle pain) was 25.3	F 505	1. The physician has been notified of the lab values from the lab report taken while Resident 3 was at the Veteran's Administration. Review of the clinical record for Resident 3 determined that there was no negative outcome from the lack of timely physician notification regarding the lab values. All residents could be at risk for failure to timely notify the physician of lab results.  2. A lab result log has been developed for each unit in which	10/10/14	

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F 505	<p>Continued From page 203 (normal range was 30 to 100). -PTH (parathyroid hormone [regulates the bodies calcium, phosphorus and vitamin D levels]) was 99.4 (normal range was 7.5 to 53.5). -Hemoglobin (carries oxygen in the blood stream and an indicator of anemia) was 11.6 (normal range was 12.5 to 17).</p> <p>Review of resident 3's interdisciplinary progress notes revealed there had been no documentation the primary care physician had been contacted with the above results.</p> <p>Interview on 9/4/14 at 11:00 a.m. with registered nurse B revealed: *The primary care physician was not notified immediately of lab values done at the Veteran's Administration. *She was unsure how the physician had been notified.</p> <p>Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 216, revealed: *The results of diagnostic and laboratory tests provide further explanation of alterations or problems identified. *You (the nurse) your results to the patient's health care provider.</p>	F 505	<p>the nurse will be responsible to document the resident name, the date the lab was drawn, the date the lab result was received, the date the physician was notified, and the nurse initials. Licensed nurses were educated on the process for using the lab result log.</p> <p>3. The MDS Case Managers will audit the lab result log daily to ensure there is timely physician notification. If issues are identified, the MDS Case Managers will report to the Director of Nursing. At the monthly QAPI meeting, the Director of Nursing will provide a report if there are any issues related to timely notification of lab results.</p>		
F 514 SS=E	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p>	F 514			

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F 514	<p>Continued From page 204</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, and interview, the provider failed to ensure: *Care plans and medical records were available to staff in one of one memory care unit for eleven of eleven residents. *Narcotic count records were available. Findings include:</p> <p>1. Observations throughout the survey from 9/2/14 through 9/11/14 revealed care plans and medical records for all residents in the memory care unit were outside the locked door. The records were in the nursing station on Warren wing.</p> <p>Interview on 9/10/14 at 7:50 a.m. with CNA S revealed they had access to the medical records for awhile. Someone had decided to move the medical records off the wing. She was unaware of who had made that decision. She agreed they would have to leave the unit and residents to get to the care plans and medical records. During the afternoons there was only one CNA working in the memory care unit.</p> <p>An interview with the director of nursing was not conducted as she was new to her position.</p>	F 514	<p>1. CNAs on the memory care unit have up-to-date pocket care cards. The nurse who oversees the memory care unit has access to the medical records on the Warren wing, where the memory care unit is located. The nurses have access to the key fob that unlocks the medication room, the Director of Nursing maintains the key for the narcotic destruction box, and the narcotic records are kept with the medication cards and bottles.</p> <p>2. The Director of Nursing will report, on a continuous basis, during the monthly QAPI meeting on any issues related to reconciliation and destruction of controlled medications.</p>	10/10/14

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F 514	Continued From page 205  There were no provider policies addressing the above concerns for the memory care unit. Surveyor: 22452 2. Observation from 9/9/14 at 10:00 a.m. through 11:00 a.m. of the east, center, and Warren medication rooms revealed: *Locked boxes that contained multiple medication cards and bottles of controlled medications for destruction by the director of nursing (DON) and the pharmacist. *The DON was the only one that had a key to the locked boxes. *The nurses would put medication cards/bottles through an opening in the top of the boxes when the medications had been discontinued or when a resident had been discharged. *Multiple medication cards and bottles did not have an accompanying narcotic record to verify the amount of medication placed in the locked boxes for what was destroyed by the DON and the pharmacist.  Interview at that time with the DON regarding the missing narcotic records revealed: *They should have been placed in the locked boxes along with the medication card or bottle. *Some of them had been put in the residents' medical records instead of being put with the medication card or bottle in the locked boxes. *Some of the narcotic records were missing altogether.	F 514			
F 520 SS=F	Refer to F431, finding 1. 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520			

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F 520	<p>Continued From page 206</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on interview and record review, the provider failed to have a system in place to identify deficient issues, develop action plans, and implement appropriate interventions to improve performance measures for their facility. Findings include:</p> <p>1. Interview on 9/9/14 at 4:00 p.m. with the environmental director revealed: *He had been a member of the quality assurance team.</p>	F 520	<p>1. All staff were educated on the QAPI program and how they can contribute to identifying issues for performance improvement.</p> <p>2. The Administrator and leadership team will develop a QAPI policy and procedure, and a system to identify issues that encompass a wide range of data sources from all departments, and residents and responsible parties.</p> <p>3. The governing body will participate in the monthly QAPI meetings for the next year to monitor the development and implementation of a QAPI program that addresses all the required components of the QAPI policy and procedure. Participation of the governing body will continue until the QAPI program is determined to be functioning effectively to identify a broad range of quality issues and implement performance improvement plans for corrective action.</p>	10/10/14	

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F 520	<p>Continued From page 207</p> <ul style="list-style-type: none"> <li>*The team met every month.</li> <li>*The members of the team consisted of the department heads.</li> <li>*The department heads provided updates on what they had been working on.</li> <li>*There were no sub-committees developed to address identified issues, and no tracking tools used to evaluate improvement.</li> </ul> <p>Interview and the June through August 2014 QA agenda review on 9/9/14 at 4:10 p.m. with social services designee YY revealed:</p> <ul style="list-style-type: none"> <li>*She had been a member of the quality assurance team.</li> <li>*The members of the team consisted of the department heads.</li> <li>*The department heads provided updates on what they had been working on.</li> <li>*The administrator would e-mail the department head prior to the meeting to find out what they wanted to have on the agenda.</li> <li>*She had one item, "Marketing for the Warren wing" on the agenda for June, July, and August 2014.</li> <li>*There were no other staff that assisted her with the goal.</li> <li>*She would provide update on things she had attempted.</li> <li>*There were no sub-committees developed to address identified issues, and no tracking tools used to evaluate improvement.</li> </ul> <p>Interview on 9/9/14 at 4:30 p.m. with accounts receivable specialist ZZ revealed:</p> <ul style="list-style-type: none"> <li>*She had been a member of the quality assurance team.</li> <li>*The members of the team consisted of the department heads.</li> <li>*The department heads provided updates on</li> </ul>	F 520		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105</b>		
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F 520	<p>Continued From page 208 what they had been working on. *There were no sub-committees developed to address identified issues and no tracking tools used to evaluate improvement.</p> <p>Interview on 9/9/14 at 4:40 p.m. with certified nursing assistant JJ revealed she had not been aware of the quality assurance committee. She was unaware of how to access the committee.</p> <p>Interview on 9/9/14 at 4:45 p.m. with certified nursing assistant RR revealed she had not been aware of the quality assurance committee. She was unaware of how to access the committee.</p> <p>Interview on 9/9/14 at 4:50 p.m. with medication technician XX revealed he had not been aware of the quality assurance committee. He was unaware of how to access the committee.</p> <p>Interview on 9/10/14 at 8:10 a.m. with the administrator revealed: *The quality assurance committee had not identified several of the issues found on this survey. *They had no system in place to identify issues, create action plans, implement interventions, and evaluate the effectiveness of those interventions.</p>	F 520		

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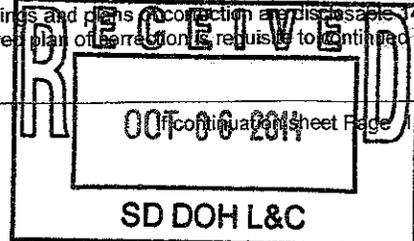
NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105
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K 000	INITIAL COMMENTS  Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/9/14. Southridge Health Care Center 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 and the Fire Safety Evaluation System (FSES) dated 9/9/14 upon correction of the deficiencies identified below.  Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K050, K062, and K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 10/6/14 telephone to facility administrator. JBS/DOH/L&C  Waiver K069 3/11/15	
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1  This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the	K 033		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>MA TS B</i>	TITLE Administrator	(X6) DATE 10-3-14
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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K 033	Continued From page 1 provider failed to maintain a one hour fire resistive path of egress from one of three basements (center wing) to the exterior of the building. The center wing basement stairways discharged into the corridor system on the main level. Findings include:  1. Observation at 9:00 a.m. on 9/9/14 revealed the center basement wing contained two remote exits. One of the exits discharged directly to the exterior with the second discharging into the corridor system. Review of previous survey data confirmed that condition had existed since the original construction.  The building meets the FSES. Please mark an "F" in the completion date column (x5) to indicate correction of the deficiencies identified in K000.	K 033		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation, record review, and interview, the provider failed to conduct quarterly fire drills during each of the three shifts. Fire drills	K 050	Environmental Services Director(ESD) will conduct an fire drill for October the week of Oct 5th - Oct 10th. Along with the Oct fire drill, ESD will conduct fire extinguisher training and fire drill procedures for all staff. November fire drill will be conducted during the 6:00am-2:00pm shift. December fire drill will be conducted during the 2:00pm-10:00pm shift. <i>x see page 3 JB/SDDH/MF</i>	<i>10/10/14 JB/SDDH/MF</i>

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K 050	Continued From page 2 were not completed each shift during two of the four previous quarters for the twelve month period beginning July 2013. The staff conducting the fire drill during the survey could not completed the procedure outlined in the provider's fire drill policy without significant coaching from the director of environmental services. Findings include:  1. Fire drill record review at 10:00 a.m. on 9/9/14 revealed no documentation indicating a fire drill was conducted for the second (3 p.m.-11 p.m.) or the third (11 p.m.-7 a.m.) shifts during the fourth quarter 2013 (October through December). A fire drill was also not documented for the third shift (11 p.m.-7 a.m.) during the second quarter 2014 (April through June). Interview with the director of environmental services during the record review confirmed the missing fire drills had not been completed. This deficiency would affect the fire safety of the entire facility.  2. During the fire drill conducted at 1:45 p.m. on 9/9/14 two staff responded to the simulated fire. Following discovery of the simulated fire they argued as to which one would make the overhead page to announce the fire drill. The director of environmental services had to direct one of the staff to make the announcement, remind them the fire alarm was to be activated, and talk them through the remainder of the fire drill procedure. Interview with the director of environmental serviced following completion of the fire drill indicated the two staff that conducted the drill were new, but they should have been trained in the fire drill procedure. This deficiency would affect the fire safety of the entire facility.	K 050	<i>x ESO will be responsible to make sure fire drills are completed as required. The administrator will be responsible to make sure ESO has completed the required drills and report findings to the quality assurance committee quarterly</i> <i>09/30/2014</i>		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 062			

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K 062	<p>Continued From page 3</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on record review and interview, the provider failed to ensure the automatic sprinkler system had the five year internal inspection completed in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Findings include:</p> <p>1. Review of the provider's automatic sprinkler system inspection, testing, and maintenance reports at 11:00 a.m. on 9/9/14 revealed an annual inspection had been completed by Building Sprinkler Company. None of the annual sprinkler system reports for the previous five years indicated a five year internal inspection had been completed. Interview with the director of environmental services at the time of the record review revealed he was unable to confirm that testing had ever been completed. This deficiency could affect the safety of all residents due to fire and smoke.</p>	K 062	<p>ESD has contacted Vendor "Building Sprinkler Company" to confirm five year internal inspection will be completed on next quarterly</p> <p><i>* ESD will be responsible to make sure work has been completed and report to Quality Assurance committee quarterly for further recommendations. JB/SDDH/ME</i></p>	<p><i>* 10/10/14 JB/SDDH/ME</i></p>
K 069 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>This STANDARD is not met as evidenced by:</p>	K 069	<p>ESD has reported that the Ansul System in kitchen will be hooked to the fire panel, which will need to be updated to accept the added zones of the building.</p>	<p><i>* 10/10/14 JB/SDDH/ME</i></p>

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K 069	Continued From page 4 Surveyor: 14180 Based on document review and interview, the provider failed to ensure the kitchen hood fire suppression system was connected to the building's fire alarm signaling system for one of one kitchen hood. Findings include:  1. Document review at 11:30 a.m. on 9/9/14 of the commercial kitchen equipment inspection report for the April 2014 inspection identified the kitchen hood fire suppression system was not connected to the building fire alarm system. Interview with the director of environmental services at the time of the document review revealed he was unaware of the requirement. He contacted the service company to verify the hood fire suppression system was in fact not connected to the fire alarm system. The service company confirmed it was not connected. This deficiency could affect the safety to staff and residents due to fire and smoke.	K 069	Vendor "Automatic Security" will conduct the bid. Vendor "All Phase Electric" will conduct the bid for all electrical needs on the project.  * [REDACTED] JB/SDDOH/MF  * ESD will be responsible to make sure work has been completed and report to quality Assurance committee quarterly for further recommendations. JB/SDDOH/MF	

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S 000	Initial Comments  Surveyor: 22452 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 9/2/14 through 9/11/14. Southridge Health Care Center was found not in compliance with the following requirements: S139, S206, S280, S294, S296, and S300.	S 000		
S 139	44:04:02:08 LINENS  The supply of bed linen and towels shall equal three times the licensed capacity. There must be written procedures for the storage and handling of soiled and clean linens. Facilities must contract with commercial laundry services or the laundry service of another licensed health care facility for all common use linens if laundry services are not provided on the premises. Facilities providing laundry service must have adequate space and equipment for the safe and effective operation of the laundry service. Commingled...residents' personal clothing, common-use linen, such as towels, washcloths, gowns, bibs, protective briefs and bedding, and any isolation clothing must be processed by methods that assure disinfection.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on observation, and interview, the provider failed to maintain a supply of bed linen and towels for all residents that equaled three times the licensed capacity. Findings include:	S 139	1. Additional linen supply was ordered and received on 9/25/14. This has ensured a proper ratio of linen supply for each resident. 2. The Environmental Services Director will monitor the levels monthly to maintain a supply of bed linens and towels for all residents that equal three times the licensed bed capacity. The laundry personnel are responsible for evaluating the condition of the bed linens and towels, discarding items that are no longer usable, and adding a checkmark to the needed linen supply checklist. Washcloths that have some use but are still intact will be repurposed for personal hygiene related to bowel and bladder care.	10/10/14

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

TITLE

(X6) DATE

*[Signature]*

*Administrator*

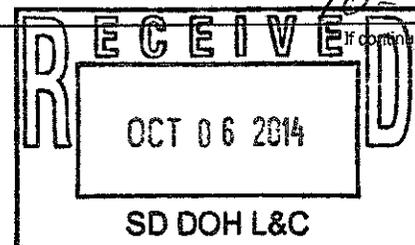
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If continuation sheet 1 of 14



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S 139	<p>Continued From page 1</p> <p>1a. Observation on 9/3/14 at 9:40 a.m. with resident 6 in his room revealed: *A bed in the corner with a blue mattress without any sheets or covering over the mattress. *There was a folded blanket on the bottom half of his mattress. *There was a pillow without a pillow case at the top half of his mattress.</p> <p>Interview at the above time with resident 6 revealed he: *Usually had to "holler" to have had his bed made. *Sometimes would go to bed at night and his bed had no sheets. *Stated he preferred to have his bed made.</p> <p>Interview on 9/3/14 at 10:15 a.m. with housekeeping assistant W on the east hall revealed: *Nursing was responsible for making the residents' beds each day. *Each bed needed a fitted sheet, a flat sheet, a pillowcase, and a blanket. *The facility had been "short sheets" for the residents. *The laundry had been low on staffing. *The linen room on the east hall was to have supplied all the linen for the residents on that hall. *There were not enough sheets and towels for each resident on the east hall due to the lack of linen.</p> <p>Observation on 9/3/14 at 10:25 a.m. in the linen room located across from the medical records office on the east wing revealed: *There were white wire shelves labeled with the following: -Washcloths.</p>	S 139	<p>The facility policy related to storage and handling of soiled and clean linens will be reviewed for necessary revisions. An evaluation of laundry staffing hours will be reviewed for revision to ensure the availability of laundry support.</p> <p>3. The Environmental Services Director will provide a report at monthly QAPI, on a continuous basis, regarding the linen supply, process of repurposing and discarding used linen, and laundry support related to staffing hours.</p>	

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S 139	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>-Towels.</li> <li>-Hand towels.</li> <li>-Gowns.</li> <li>-Pillowcases.</li> <li>-Fitted sheets.</li> <li>-Flat sheets.</li> </ul> <p>*On those shelves there were only six pillowcases and no other linen. *There were two covered linen carts in that same room. *Those two carts contained the following: -One of the carts had nothing in it. -The other cart was approximately one-half full of blankets and heel protectors. -There was no linen on those carts.</p> <p>Interview on 9/3/14 at 10:32 a.m. with certified nursing assistant (CNA) X on the east hall in the same location as the above revealed: *There were rooms for thirty-three residents on the east hall. *There were currently thirty residents on that hall. *She stated beds had been changed one to two times per week with the residents' bath schedules and as needed. *She stated there were not enough sheets, towels, and soaker pads (used on resident beds) for all the residents on the east hall.</p> <p>Interview on 9/3/14 at 10:45 a.m. with CNA Y on the east hall regarding resident 6's linen on his bed revealed: *She had helped him get up that morning. *It had been the responsibility of the nursing staff person who assisted him with getting up in the morning to have made his bed. *She had been unable to make his bed that morning, because there had not been any sheets in the linen closet. *She stated she would have needed to go to the</p>	S 139		

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NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900S NORTON AVENUE SIOUX FALLS, SD 57105</b>		
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S 139	<p>Continued From page 3</p> <p>laundry located on the center hall to obtain the linen to have made his bed.</p> <p>Observation and interview on 9/3/14 at 10:50 a.m. with CNA Z on the east hall revealed he stated he:</p> <ul style="list-style-type: none"> <li>*Had obtained the following from laundry located on the center hall for resident 6: <ul style="list-style-type: none"> <li>-One towel.</li> <li>-One fitted sheet.</li> <li>-One flat sheet.</li> <li>-One pillow case.</li> <li>-One soaker pad.</li> </ul> </li> <li>*Had obtained no other linen from laundry for any other residents on the east hall.</li> </ul> <p>Observation on 9/3/14 at 11:05 a.m. with resident 6 in his room revealed his bed had been made.</p> <p>b. Observation and interview on 9/3/14 at 11:00 a.m. with CNA D on the center hall in the linen room revealed:</p> <ul style="list-style-type: none"> <li>*Shelves were approximately one-fourth full of resident towels, sheets, and gowns.</li> <li>*There was a covered linen cart with nothing in it.</li> <li>*She stated they usually looked like that except "it was more full on weekends, because residents did not get showers then."</li> <li>*She stated there were rooms for fifty residents on the center hall.</li> <li>*There were currently forty-six residents on that hall.</li> <li>*She stated there was not enough sheets, towels, and soaker pads for all the residents on the center hall.</li> </ul> <p>Surveyor: 16385</p> <p>c. Observation on 9/4/14 from 8:00 a.m. to 8:40 a.m. of the east linen room, the center linen</p>	S 139		

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NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3900S NORTON AVENUE SIOUX FALLS, SD 57105		
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S 139	<p>Continued From page 4</p> <p>room, the Memory Care linen room, and the laundry room revealed:</p> <p>*The east linen room contained:</p> <ul style="list-style-type: none"> <li>-Two fitted sheets (photo 1).</li> <li>-Six sheets (photo 2).</li> <li>-Four gowns (photo 3).</li> <li>-No soaker pads (photo 4).</li> </ul> <p>*The center linen room contained:</p> <ul style="list-style-type: none"> <li>-Four fitted sheets (photo 5).</li> <li>-Eight sheets (photo 6).</li> <li>-No soaker pads.</li> </ul> <p>*The Memory Care linen room contained:</p> <ul style="list-style-type: none"> <li>-No fitted sheets.</li> <li>-Seven sheets (photo 7).</li> <li>-Three soaker pads (photo 8).</li> </ul> <p>*The laundry room contained twelve new sheets in the packages (photo 9).</p> <p>Interview on 9/4/14 at 8:35 a.m. with laundry worker R revealed laundry had been requested by the nursing staff to deliver linens to the east linen room and the center linen room. Both of those halls were running out of linen.</p> <p>Observation on 9/4/14 from 1:25 p.m. to 2:00 p.m. revealed:</p> <p>*The east linen room contained:</p> <ul style="list-style-type: none"> <li>-Thirteen fitted sheets.</li> <li>-Thirty-three sheets.</li> <li>-Thirty-nine soaker pads.</li> </ul> <p>*The center linen room contained:</p> <ul style="list-style-type: none"> <li>-Nine fitted sheets.</li> <li>-Eight sheets.</li> <li>-Thirty soaker pads.</li> </ul> <p>*The Memory Care linen room contained:</p> <ul style="list-style-type: none"> <li>-No fitted sheets.</li> <li>-Seven sheets.</li> <li>-Two soaker pads.</li> </ul> <p>d. Interview on 9/4/14 at 11:00 a.m. with the</p>	S 139		

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NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3900S NORTON AVENUE SIOUX FALLS, SD 57105		
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S 139	Continued From page 5  director of environmental services revealed: *He was not aware of the requirement for the provider to have had a supply of bed linens for all residents that equaled three times the licensed capacity. *They did not have a linen policy.	S 139		
S 206	44:04:04:05 PERSONNEL-TRAINING  The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks , and hydration needs of...residents.  ...Additional personnel education shall be based on facility identified needs.  This Administrative Rules of South Dakota is not met as evidenced by:	S 206	1. The in-service calendars were updated to include all of the required annual training topics. 2. The in-service calendar will be managed by the new Staff Development Coordinator, and she will track staff participation in the required in-service education. Lack of participation by any staff person will be reported to the Administrator. 3. The Administrator will provide a report during the monthly QAPI meeting, on a continuous basis, progress towards meeting the required annual training topics. The QAPI committee will provide input on additional in-service topics related to QAPI activity and competency evaluations.	10/10/14

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S 206	Continued From page 6  Surveyor: 32332 Based on annual training record review and interview, the provider failed to ensure one of ten mandatory topics (proper use of restraints) was covered for all personnel. Findings include:  1. Review of the provider's all-staff inservice calendars for 2013 and 2014 revealed the mandatory proper use of restraints topic had not been covered in the last calendar year.  Interview on 9/10/14 at 2:10 p.m. with the director of nursing regarding the above revealed: *She confirmed the proper use of restraints topic had not been provided to all staff members. *They did not have a policy on the mandatory training topics. *She had initially been hired to do the training, but was now in the interim DON position.	S 206		
S 280	44:04:06:04 NURSING POLICIES AND PROCEDURES  Policies and procedures that provide the nursing staff with methods of meeting its administrative and technical responsibilities in providing care to...residents must be established and maintained. The policies must include at least the following: (1) The noting of diagnostic and therapeutic orders; (2) Assigning the nursing care of...residents; (3) Administration and control of medications; (4) Charting by nursing personnel; (5) Infection control; (6) ...resident safety; and (7) Delineation of orders from nonphysician practitioners.	S 280	1. The Staff Development Coordinator, in collaboration with the consultant pharmacist, provided education to the unlicensed assistive personnel (i.e., medication aide).  2. Policies and procedures, including applicable forms, are being revised or written for the following areas: a. Physician notification b. Grievance procedure c. Physical restraints	10/10/14

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S 280	Continued From page 7  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32332 Based on interview, record review, and policy review, the provider failed to ensure annual medication (med) aide training was completed for six of six unlicensed assistive personnel (UAP) ((P, RR, TT, AAA, BBB, CCC) who have been employed longer than one year. Findings include:  1. Interview and record review of med aide training on 9/8/14 at 8:15 a.m. with the director of nursing (DON) revealed the med aides had received training upon being hired. An evaluation of their skills and competency was reviewed if they had been trained in another institution prior to being hired. She had been unable to locate any proof of ongoing med aide training after being hired for those six UAPs who had been hired over one year.  Interview on 9/9/14 at 4:30 p.m. with the DON revealed: *She had called the provider's consultant pharmacist and had been told the pharmacy had last provided medication training to med aides three years ago. *She agreed annual med aide training should have been done.  Review of the provider's June 2014 Medication Aide (UAP) Competency Guidelines Policy and Procedure revealed no ongoing medication training expectations for med aides.	S 280	d. Bathing and weights e. Investigation policies f. Skin program g. Incident reporting h. Evening snacks i. Infection control j. Quality assurance k. Assigning nursing care of residents l. Administration and control of residents The Staff Development Coordinator is designated the responsibility for maintaining current policy and procedure manuals. 3. The Staff Development Coordinator will provide a report monthly, on a continuous basis, for at least 90 days, on the progress of policies being revised and the education provided on them. These reports will occur until the QAPI committee determines otherwise.	
S 294	44:04:07:04 Written Menus	S 294		

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S 294	<p>Continued From page 8</p> <p>Any regular and therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, must be written, prepared, and served as prescribed by each...residents's physician. Each menu must be written at least one week in advance. Each planned menu must be approved, signed, and dated by the dietitian for all facilities. Any menu changes from month to month must be reviewed by the dietitian and each menu must be reviewed and approved by the dietitian at least annually where applicable. Each menu as served must meet the nutritional needs of the...residents in accordance with the physician's orders and the Recommended Dietary Allowances of the National Research Council.. Tenth Edition, 1989. Records of menus as served must be filed and retained for 30 days.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on interview, record review, and policy review, the provider failed to ensure the planned menu for regular and therapeutic (treatment of disease) diets for all residents on oral diets was reviewed and approved by the consultant registered dietitian (RD) at least annually. Findings include:</p> <p>1. Record review on 9/03/14 of the planned menu for regular and therapeutic diets revealed: *The menus had been last reviewed and approved on 4/20/13 by the consultant RD. *The menu review and approval had not been completed at least annually.</p> <p>Interview on 9/9/14 at 2:20 p.m. with the</p>	S 294	<ol style="list-style-type: none"> <li>1. The new Dietary Manager and the Registered Dietitian met to develop a plan for reviewing and revising the written regular and therapeutic diet menus.</li> <li>2. The menus will be reviewed and revised at least annually and signed by the Registered Dietitian, and as needed.</li> <li>3. The Registered Dietitian will report on resident satisfaction and the accuracy of the planned menus regarding the nutritional adequacy, on a continuous basis, during the monthly QAPI.</li> </ol>	10/10/14

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S 294	Continued From page 9  consultant RD revealed: *She had been the consultant RD at the facility for several years. *The menu for regular and therapeutic diets for all residents on oral diets had not been reviewed and approved at least annually. *She agreed that menu needed to have been reviewed and approved at least annually.  Review of the provider's 7/16/14 Menus policy revealed: *Menus would have been evaluated and approved by a South Dakota licensed RD. *The policy did not state the menus would have been evaluated annually.	S 294		
S 296	44:04:07:07 Director of dietetic services  A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved the Dietary Managers Association, must enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Dietary Managers Association, or successfully completed equivalent training as determined by the Health Department. The dietetic manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each...resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian	S 296	1. The new dietary manager will be scheduled to attend a qualified certification course. 2. A qualified dietary consultant will be secured to provide mentoring with the dietary manager until successfully completing the certification course. 3. The Registered Dietitian will provide a report on progress towards completing the certification course at the monthly QAPI meeting, until the QAPI committee determines otherwise.	10/10/14

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S 296	<p>Continued From page 10</p> <p>must approve all menus, assess the nutritional status of...residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are scheduled to meet the dietetic needs of the...residents must be on duty daily over a period of 12 or more hours in nursing facilities...</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on interview and record review, the provider failed to ensure at least one cook had successfully completed and had a current certificate from a ServSafe Food Protection Program or the Certified Food Protection Professional's Sanitation Course, or had successfully completed equivalent training. Findings include.</p> <p>1. Record review revealed the certified dietary manager (CDM) had a current ServSafe Food Protection Program certificate.</p> <p>Interview on 9/2/14 at 6:05 p.m. and on 9/9/14 at 4:10 p.m. with the certified dietary manager (CDM) revealed: *The dietary department did not have at least one cook who had successfully completed and possessed a current certificate from any of the following: -ServSafe Food Protection Program. -Certified Food Protection Professional's Sanitation Course. -Any other equivalent training. *She stated the provider did not have a policy regarding the above.</p> <p>Interview on 9/9/14 at 2:30 p.m. with the</p>	S 296		
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S 296	Continued From page 11  consultant registered dietitian regarding at least one cook who had successfully completed the above program, course, or equivalent training revealed: *She stated the CDM was the only staff person in the kitchen with a current ServSafe Food Protection Program certificate. *She confirmed there were no cooks on staff that had completed the program, course, or equivalent training. *She agreed there needed to be at least one cook in addition to the CDM that had completed the program, course, or equivalent training.	S 296		
S 300	44:04:07:14 Nutritional assessments  A registered dietitian shall ensure a nutritional assessment is completed on each new resident upon admission; any resident having a significant change in diet, eating ability, or nutritional status; monthly for any resident receiving tube feedings; and on any resident with a disease or condition that puts the resident at significant nutritional risk. A monthly tube feeding assessment must include nutritional adequacy of calories, protein, and fluids. An annual assessment shall be completed for each resident.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure two of two residents (9 and 14) on a tube feeding (tube into stomach) had a monthly assessment by a registered dietitian (RD) that had included nutritional adequacy of calories, protein, and fluids. Findings include:	S 300	1. The Registered Dietitian completed a nutritional assessment on Residents 9 and 14. 2. The Registered Dietitian will develop a log of residents who have conditions that require monthly nutritional assessments to ensure those assessments are completed timely. The Registered Dietitian will participate in the weekly Wound and Weight committee meetings. 3. At monthly QAPI meetings, the Director of Nursing and consultant Registered Dietitian will provide a collaborative report from the Wound	10/10/14

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S 300	<p>Continued From page 12</p> <p>1. Review of resident 14's medical record revealed he:                      *Had an admission date of 7/3/14.                      *Had physician's orders dated 7/3/14 for "NPO [no food by mouth] Diet." "Jevity 1.2 [a tube feeding formula] at 80 cc [cubic centimeters] for 11 hours start at 0500 [5:00 a.m.] and end at 1600 [4:00 p.m.] 240 cc free water flush four times daily."                      *Had been on a tube feeding since admission.</p> <p>Review of resident 14's 7/7/14 Nutrition History &amp; Data Collection Form by the consultant RD revealed no nutritional assessment regarding nutritional adequacy of calories, protein, or fluids.</p> <p>Review of resident 14's 7/11/14 and 8/24/14 Interdisciplinary Progress Notes by the consultant RD revealed no nutritional assessment regarding nutritional adequacy of calories, protein, or fluids.                      Surveyor: 33265</p> <p>2. Review of resident 9's medical record revealed he:                      *Had an admission date of 2/1/12.                      *Had two physician's orders for Jevity tube feeding formula dated:                      - 5/27/14 for Jevity 1.0 to run at 85 cc per hour for 16 hours. It was to run from 5:00 p.m. until 9:00 a.m. the next morning.                      - 6/23/14 for 300 cc of Jevity 1.0 to start at noon and run for one and a half hours (300 cc per hour).                      *Had two physician's orders for water flushes of the tube used for tube feedings dated:                      - 7/23/14 for 200 cc of water to flush the feeding tube every four hours.                      - 8/12/13 for 200 cc of water before and after each feeding.                      *Had no monthly review for July 2014 completed</p>	S 300	and Weight committee meetings, on an ongoing basis.	

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S 300	<p>Continued From page 13 by the consultant RD.</p> <p>Surveyor: 32331</p> <p>3. Interview on 9/9/14 at 10:35 a.m. with the consultant RD regarding the residents' monthly tube feeding assessments revealed she:</p> <ul style="list-style-type: none"> <li>*Had not included nutritional adequacy of calories, protein, and fluids.</li> <li>*Agreed the above needed to have been done at least monthly.</li> </ul> <p>Review of the provider's 2/16/14 Clinical Nutrition Services policy revealed the consultant RD was to have been responsible for completing a monthly tube feeding assessment that included nutritional adequacy of calories, protein, and fluids.</p>	S 300		
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