

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

**ORIGINAL**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435049</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - SALEM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 COLONIAL DRIVE SALEM, SD 57058</b>
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F 000	INITIAL COMMENTS  Surveyor: 32335 A partial extended/recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 12/16/14 through 12/18/14. Golden LivingCenter - Salem was found not in compliance with the following requirement(s): F157, F166, F224, F241, F250, F253, F279, F281, F314, F315, F356, F431, F441, F456, and F466.	F 000	<p>Addendums noted with an asterisk per 1/20/15 telephone and email to facility administrator. KE/KDDH/MF</p> <p>Printer Technical difficulties... For F157 - Please start on page 3, then go to page 2! UGB</p>	
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 specified in §483.15(e)(2); or a change in resident rights under Federal or State law or	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Quonica J. Smith</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>1/15/15</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1 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: 33488 Based on record review, interview, and policy review, the provider failed to notify the physician a resident had not received his medications as ordered for one of twelve sampled residents (6). Findings include:</p> <p>1. Review of resident 6's medical record revealed: *He was admitted on 12/12/14 with diagnoses of kidney disease needing dialysis, diabetes, high blood pressure, chronic pain, depression, Clostridium difficile (C-diff) (a bacterial infection found in the intestinal tract) infection, and a healing clavicle (collarbone) fracture. *He required kidney dialysis treatment three times per week. *His current medication administration record (MAR) had several "7s" marked on December 13 and 15. *The Charting Codes/Follow Up Codes legend found on the bottom left corner of the MAR revealed "7" meant to refer to "Other/See Nurses Notes."</p> <p>Progress Notes for resident 6 documented by nursing revealed: *Two entries labeled "e-MAR-medication</p>	F 157	<p>Residents residing in the facility who receive medication have the potential to be affected in a similar manner.</p> <p>A medication audit was completed to identify any other residents who may have received medications as ordered and appropriate notifications were completed. One other resident identified with a missed treatment. Physician notified 1/13/15.</p> <p>Executive Director, Director of Nursing and Medical Director have reviewed the Golden Living Notification of Change in Resident Health Status guideline, Clinical Health Status Change in Condition Guideline and SBAR tool and have found them to be appropriate. Alixa pharmacy utilizes multiple pharmacies in Sioux Falls, SD as well as the local pharmacy for STAT delivery of medications.</p> <p>Licensed Nursing staff will be reeducated using Golden Living Notification of Change in Resident Health Status, Clinical Health Status Change in <i>go to page 6</i></p>	

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F 157	<p>Continued From page 2</p> <p>administration note" both made on December 13, 2014 at 4:22 a.m. of "This medication has not arrived yet."</p> <p>*Two entries labeled "e-MAR-medication administration note" dated 12/14/14 at 11:33 p.m. of "unavailable medication."</p> <p>*Two entries labeled "e-MAR-medication administration note" dated 12/15/14 at 5:03 a.m. and 5:04 a.m. of "unavailable medication."</p> <p>Interview on 12/17/14 at 11:45 a.m. with licensed practical nurse (LPN) K regarding the above MAR documentation revealed:</p> <p>*She had worked December 13 and 14 (2014).</p> <p>*She stated those medications had not yet arrived from the pharmacy which was located out-of-state.</p> <p>*Those medications not given and check marked as "7" on the MAR were not available in the AlixaRx (automated medication dispensing machine) at that time.</p> <p>Interview on 12/17/14 at 12:55 p.m. with dialysis registered nurse (RN) T by phone regarding resident 6 revealed they (dialysis center) did not administer medications to residents. Those medications were to be given before or after the resident has had dialysis.</p> <p>Interview on 12/18/14 at 9:20 a.m. with LPN C regarding resident 6's MAR revealed medications marked with a "7" on the MAR were unavailable to be administered. Those medications were:</p> <p>*Atrac-Tain cream- (for dry skin) to be given three times per day but had not been given twice on December 13, once on December 14, and twice on December 15, 2014</p> <p>*Flagyl- (for treat C-diff) to have been given three times per day but had not been given on</p>	F 157	<p><b>STATEMENT OF COMPLIANCE:</b></p> <p>The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on December 18, 2014. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of January 20, 2015. The completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing on the part of the living center. This plan of correction is completed in good faith and as the living center's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.</p> <p><b>F 157 Notifications of Changes</b></p> <p>Resident # 6's physician was notified the resident had not received his medication as ordered 12/17/14</p>	

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F 157	<p>Continued From page 3 December 15, 2014.</p> <p>*Amoxicillin- (antibiotic for the resident's urinary tract infection) was to be given one time per day but had not been given on December 15, 2014.</p> <p>*Celexa- (for depression) to be given one time per day but had not been given on December 15, 2014</p> <p>*Carvedilol- (for high blood pressure) to be given two times per day but had not been given on December 15, 2014.</p> <p>*Pulmicort- (breathing treatment) to be given two times per day had not been given the mornings of December 13 and 15.</p> <p>*Flomax- (used to treat an enlarged prostate) was to be given one time per day but had not been given on December 15, 2014.</p> <p>*Lidocaine patch- (pain reliever) was to be applied one time per day had not been given on December 15, 2014, nor had the previous days medication patch been removed.</p> <p>*Nephrocaps capsule- (helps the kidneys function better) to be given one time per day but had not been given on December 15, 2014.</p> <p>*Gabapentin- (for nerve pain) to be given four times per day had not been given on December 15, 2014</p> <p>*She had reported the unavailable medications to the director of nursing (DON) and reported it to the oncoming shift as instructed.</p> <p>*She had not notified the physician of the error.</p> <p>Interview on 12/18/14 at 1:30 p.m. with the DON and administrator regarding the above medications not being given to resident 6 revealed: *The DON stated: -She was not aware the resident had not received medications for those days listed above. -She thought the medications had been given</p>	F 157			

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F 157	<p>Continued From page 4 during his time at dialysis. -Unavailability of medications should have been reported by staff as a medication error. *Their expectation was the physician should have been called and notified the resident had not received his medications December 13 and again on Dec 15, 2014.</p> <p>Review of the provider's 11/12/14 Notification of Change in Resident Health Status revealed physician notification should have occurred as soon as possible, no longer than twenty-four hours.</p> <p>Review of the provider's May 2012 Unavailable Medications policy revealed: **"Nursing staff should have notified the physician of the situation and explain the circumstances, expected availability (of the medication) and optional therapies that are available." **"Obtain a new order and cancel/discontinue the order for the non-available medication." **"Notify the pharmacy of the replacement order."</p> <p>Review of the provider's May 2012 Medication Ordering and Receiving From Pharmacy policy revealed: **"Stat" and emergency medications were available within four hours during regular business hours. *After hours the pharmacy was called and medication is taken from the emergency supply if available. *The pharmacy would determine the appropriate method for obtaining it.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 358, revealed, "A registered nurse makes a</p>	F 157		

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F 157	Continued From page 5 telephone report when significant events or changes in a patient's condition have occurred."	F 157	Condition Guideline and SBAR tool guideline with clear expectations of following each guideline on 1/7/15.  ↑ Director of Nursing or designee will complete daily audits x 4 weeks, weekly x 2 months to ensure medications were administered as ordered. DON will report results of the audits and they will be reviewed by the QAPI committee for further recommendations monthly.	1/20/15	
F 166 SS=D	Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 582 and 583 revealed, "Medication errors include failure to administer a medication." <b>483.10(f)(2). RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</b>  A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.  This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Preceptor: 33488 Based on interview, record review, and policy review, the provider failed to resolve grievances regarding a room change and dressing changes for 1 of 12 sampled residents (4). Findings include:  1. Interview on 12/17/14 at 12:45 p.m. with resident 4 revealed: *He voiced concerns of: -Having had to change rooms and had not been allowed to return to his old room. -Not getting dressing changes when he requested a dressing change. -The staff sometimes gave him "attitude" when he requested a dressing change. -A nurse had asked him if he had any idea how much his treatment costs.	F 166			

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F 166	Continued From page 6 Review of resident 4's interdisciplinary notes revealed: *A note dated 10/3/14 written by the licensed social worker (LSW) revealed: -Resident 4 had been moved to another room while new flooring was installed. -He requested to move back to his original room. -He had not been satisfied with the options offered to him. -He had reported his room was cold. -Room assignments were to be re-evaluated the next week. -The LSW wrote "will continue to monitor." -There had been no further documentation of monitoring or follow-up regarding the room change. *A note dated 8/22/14 written by the LSW revealed: -Resident 4 requested to speak with the LSW regarding his dressing changes. -He reported he had asked the nurse to change his dressing and was told by the nurse she had changed it earlier while he was sleeping. -The resident had not remembered that happening, and he felt he would have woken up. -The LSW "questioned resident about his dressing changes as it has been documented that he often refuses to have it changed." -The resident had denied ever refusing a dressing change. -The LSW had spoken with the licensed nurse who had been on duty who stated "the dressing change was in fact done while resident was sleeing and he did not wake up." -The licensed nurse had reported to the LSW she had talked with the resident and told him she would "wake him for the dressing change in the future." -The nurse "verified that the resident does, in	F 166	<b>F 166 Right to Prompt Efforts to Resolve Grievances</b>  Resident # 4 grievance has been reviewed with the resident. He has been offered another room in the facility which he declined on 1/5/15. Facility has explained that previous room is not available as it is now set up for short term rehab.  Residents residing in the facility who have expressed a grievance have the potential to be affected in a similar manner.  An audit of the grievance log will be completed to identify any other potentially unresolved grievances during the month of December 2014. Any identified grievances will be resolved appropriately. No additional concerns identified.  Executive Director, Director of Nursing, Social Service Director and the Interdisciplinary team have reviewed the Golden Living Grievance Guideline, Grievance Form and Grievance Tracking Form and have found them to be appropriate and		

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F 166	Continued From page 7 fact, refuse dressing change often." -The LSW wrote "will continue to monitor." -There had been no further documentation of monitoring or follow-up regarding that issue by the LSW. *On 7/26/14, two days after admission, it was documented the resident had been sleeping and refused a dressing change. -There was no further documentation of him refusing to have the dressing changed.  Interview on 12/18/14 at 4:15 p.m. with the director of nursing (DON) revealed a grievance form should have been completed when the concern was raised by the resident (4).  Review of the Long Term Care Facilities Resident's Bill of Rights provided to residents upon admission stated "the grievance process must include the facility's efforts to resolve the grievance, documentation of the grievance, names of the people involved, nature of the matter and the date."  The grievance form and accompanying policy requested, was never produced. They had no policy.	F 166	staff members will be reeducated on the Golden Living Grievance Guideline and Grievance Form with clear expectations of following the guideline during an all staff meeting scheduled January 14, 2015.  Executive Director or designee will review grievances daily during stand up meeting and monitor through appropriate resolution x 3 months. Executive Director will report the results of the audits and they will be reviewed by the QAPI committee for further recommendations monthly.		
F 224 SS=D	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.	F 224	<i>* On 1/20/15 the care plan for resident #3 was updated to check and change resident with repositioning. Kef/SDCH/ME I think I got it! now! JRS</i>  F 224 Prohibit Mistreatment/Neglect Misappropriation  Resident #3's incontinent product was checked and changed as soon as concern was brought forward.	1/20/15	

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F 224	<p>Continued From page 8</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 one of one sampled resident (3) was checked and changed for incontinence ( inability to control the bowel or bladder) according to her current individualized plan of care. Findings include:</p> <p>1. Observation on 12/18/14 at 9:40 a.m. of resident 3's mechanical lift transfer with licensed practical nurse (LPN) A and registered nurse (RN) L revealed: *She was transferred from her high back wheelchair to her bed using the mechanical lift by LPN A and RN L. *After the transfer had been completed LPN A left the resident's room. RN L was going to leave the room. *RN L when questioned about checking and changing the residents incontinent brief she stated LPN A had to leave to perform another residents dressing change. *RN L and LPN A had not had time to check and change resident 3 for incontinence of bowel and bladder. RN L stated resident 3 would let them know if she was incontinent. RN L revealed she had gotten the resident up in her wheelchair at 7:40 a.m. that morning. RN L left resident 3's room. *Neither LPN A not RN L had asked resident 3 if she was incontinent prior to exiting her room. *After waiting fifteen minutes in the hallway where resident 3 had resided no staff returned to her room.</p> <p>Review of resident 3's 10/9/14 Minimum Data Set</p>	F 224	<p>Residents residing in the facility who have the inability to control their bowel or bladder have the potential to be affected in a similar manner.</p> <p>* during the at risk meetings Assessments of residents identified with the inability to control their bowel or bladder will be reviewed and revised by the interdisciplinary team to accurately reflect the resident care needs* per their next MDS.</p> <p>Reeducation will be completed to the Interdisciplinary team utilizing the Golden Living Weekly at Risk Committee Meeting guideline with clear expectations of following the guideline* on 1/15/15. *see page 10.</p> <p>Staff members will be reeducated on the Golden Living Abuse Guideline with clear expectations of following the guideline during an all staff meeting scheduled January 14, 2015.</p> <p>Director of Nursing Services or designee will review progress notes of the weekly at risk meetings to audit that committee guidelines are met/implemented weekly x 4 weeks then monthly x</p>	

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F 224	Continued From page 9 (MDS) revealed she: *Scored a ten on her cognition (memory) status. A completely orientated (knows person, place, and time) person would score a fifteen. She had some problems with her memory. *She needed extensive assistance of two staff for dressing and personal hygiene. *She was incontinent of bowel and bladder.  Review of resident 3's 10/22/14 individualized plan of care revealed staff were to have: *Observed for skin breakdown due to incontinence. *Checked and changed her for incontinence every two hours *Provided perineal (private area) care following incontinence. *Evaluated frequency and timing of incontinent episodes.  Review of the provider's undated Reporting Alleged Violation policy revealed it was the policy of the center to take appropriate steps to prevent the occurrence of neglect. Neglect meant the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.	F 224	2 months to ensure resident's needs are being met. Director of Nursing Services will report results of the audits and they will be reviewed by the QAPI committee for further recommendations monthly.  <i>* (continued from page 9) The at risk team reviews residents with risks, for example those with incontinence, and monitors staff compliance. KE/SDDH/MF</i>	1/20/15
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by:	F 241	F 241 Dignity & Respect of Individuality  Resident #4 has received a bath Resident #2, 11, 15 and 16 dining table positioning has been reviewed and revised.	

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F 224	Continued From page 9 (MDS) revealed she: *Scored a ten on her cognition (memory) status. A completely orientated (knows person, place, and time) person would score a fifteen. She had some problems with her memory. *She needed extensive assistance of two staff for dressing and personal hygiene. *She was incontinent of bowel and bladder.  Review of resident 3's 10/22/14 individualized plan of care revealed staff were to have: *Observed for skin breakdown due to incontinence. *Checked and changed her for incontinence every two hours *Provided perineal (private area) care following incontinence. *Evaluated frequency and timing of incontinent episodes.  Review of the provider's undated Reporting Alleged Violation policy revealed it was the policy of the center to take appropriate steps to prevent the occurrence of neglect. Neglect meant the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.	<del>F 224</del> F 241	* Resident #4's care plan has been updated to "at least weekly" for baths. Resident # 2 got a new wheel-chair so that she is able to be repositioned and sit up to the table. Residents 11 and 15 will be offered assistance at meal times with napkins, food prep and positioning at the table. Resident 16 was given a plate guard, is assisted with positioning at the table, food prep and eating when needed. Care plans have been updated. KGL/DDH/MF		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by:	F 241			

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F 241	<p>Continued From page 10</p> <p>Surveyor: 35121 Preceptor: 33488</p> <p>A. Based on interview and record review, the provider failed to give baths on a weekly basis for one of four randomly interviewed residents (4). Findings include:</p> <p>1. Interview on 12/17/14 at 12:45 p.m. with resident 4 revealed he had voiced a concern of having to wait two weeks between baths.</p> <p>Review of resident 4's medical record revealed: *The resident was admitted on 7/24/14. *A full bed bath was documented as given on 8/13/14. *The next documented bath given was a full bed bath on 8/27/14. *That was fourteen days after the prior documented bath. *A full bed bath was documented as given on 9/10/14. *The next documented bath was a whirlpool bath on 9/24/14. *That was fourteen days after the prior documented bath. *There were no documented resident refusals of baths on the bathing report from admission through 10/31/14.</p> <p>Interview on 12/18/14 at 4:15 p.m. with the director of nursing and the administer regarding bathing for resident 4 revealed: *They would have expected baths to be given at least weekly unless the resident requested baths more often. *The bathing report showed more than a week had past in between some baths. *The refusal of a bath should have been marked on the bathing report.</p>	F 241	<p>Residents residing in the facility have the potential to be affected. Director of Nursing and Executive Director observed the dining room and identified four additional residents that needed additional assistance in the dining room and assistance was provided.</p> <p><i>* on 01/14/15 Kelsodhime</i> <u>Bath schedule was updated and staff were re-educated regarding expectations that residents receive a bath at least once a week, to document when a resident refuses and how to provide proper assistance in the dining room including assisting to push residents up to the table, offering additional napkins and sitting down to cue or assist in feeding. <i>* care plans were updated for dining room needs.</i> <i>Kelsodhime</i></u></p> <p>Executive Director or designee will observe the dining room daily x 3 weeks, then weekly x 4 weeks and then monthly x 2 months to ensure resident's needs are being met. Executive Director will report results of the audits and they will be reviewed by the QAPI committee for further recommendations monthly.</p>	

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F 241	<p>Continued From page 11.</p> <p>*There were no refusals of baths documented on the bathing report regarding the above dates. *They had no bathing policy.</p> <p>Surveyor: 32335 B. Based on observation, record review, and interview, the provider failed to ensure four of four randomly observed residents (2, 11, 15, and 16) were appropriately positioned at the table, and assisted when needed, so food was not being dropped onto their laps. Findings include:</p> <p>1. Observation on 12/16/14 from 12:05 p.m. through 12:30 p.m. revealed: *Resident 16 had been in a wheelchair and was not pushed up to the table. -He had been eating spaghetti and was dropping it on his clothing protector. -He used his utensils to pick up the food and eat it. *Resident 15 had not been pushed up to the table and had been sitting at an angle to the table. -She had been dropping food onto her clothing protector. *Resident 11 had been sitting at the table. -He had a plate guard on his plate that was at the top of his plate instead of on the bottom. -He had been dropping spaghetti on his lap and picking it up with his utensils and eating it. *There were no staff around to assist those residents mentioned above.</p> <p>Observation on 12/16/14 from 6:00 p.m. through 6:25 p.m. revealed: *Resident 16 had been sitting in a wheelchair away from the table with no clothing protector on. -He had been eating sauerkraut and while trying to get it to his mouth he was shaking and holding his other hand under the spoon to prevent</p>	F 241	<p>Director of Nursing Services will review baths weekly x 4 weeks to ensure that residents received a bath and that those requesting or needing more received accordingly or that it is documented that it was due to resident choice. Director of Nursing Services will report results of the audits and they will be reviewed by the QAPI committee for further recommendations monthly.</p>	1/20/15	

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F 241	<p>Continued From page 12 dropping food onto his lap. *Resident 15 had been sitting away from the table at an angle. -She had spilled soup on her clothing protector. *There were no staff assisting either of the above mentioned residents.</p> <p>Review of resident 16's 11/7/14 Minimum Data Set (MDS) assessment revealed his thinking ability was severely impaired. For eating he required limited assistance where staff provided "guided maneuvering of limbs or other non-weight bearing assistance." He required physical assistance from one staff person.</p> <p>Review of resident 15's 10/20/14 MDS assessment revealed her thinking ability was severely impaired. For eating she required "supervision, oversight, encouraging, and cueing."</p> <p>Review of resident 11's 11/10/14 MDS assessment revealed his thinking ability was not impaired. He ate independently with set-up help only.</p> <p>Surveyor: 34030 2. Observation on 12/16/14 at the noon meal of resident 2 revealed: *She had been seated in a geri-chair (geriatric chair used for ease of care with wheels and reclines as needed). *The geri-chair had been reclined back as far as it would go, so the resident was lying back at the table instead of sitting upright to eat. *The chair and resident were placed to the side of the table instead of facing it. *Spaghetti had been served, and there were spaghetti noodles in the resident's lap.</p>	F 241		

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F 241	<p>Continued From page 13</p> <p>*The resident was feeding herself.</p> <p>*The positioning of the resident had made it difficult for her to eat and presented a choking hazard.</p> <p>Interview on 12/16/14 at 12:20 p.m. with certified nursing assistant S revealed the "chair won't sit up properly."</p> <p>Interview on 12/16/14 at 12:30 p.m. with the dietary manager revealed she was aware the chair had not been working. She agreed it would be difficult for resident 2 to eat her meals in the reclining back position.</p> <p>Interview on 12/16/14 at 3:00 p.m. with the director of nursing revealed: *She had been unaware the chair was not working. *No manufacturer's instructions regarding use for the geri-chair had been found.</p> <p>Surveyor 32335: Interview on 12/18/14 at 2:30 p.m. with the DON and the administrator revealed: *They knew there were issues in the dining room and had planned to address those issues in February. *Residents should have been positioned up to the table. *The had no policy that addressed dignity in the dining room or in general.</p>	F 241		
F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial</p>	F 250		

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F 250	<p>Continued From page 14 well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and job description review, the provider failed to ensure social services interventions were provided for two of seven sampled residents (1 and 4) with depression. Findings include:</p> <p>1. Random observations from 12/16/14 through 12/18/14 of resident 1 revealed: *The privacy curtain had been pulled completely when she had been observed in her room. *The light on her side of the room had been turned off during all the random observations.</p> <p>Observation and interview on 12/17/14 at 10:40 a.m. with resident 1 revealed: *The privacy curtain had been pulled completely to separate her side of the room from the other resident. *The light on her side of the room had been turned off. *The window curtain had been pulled shut. *She had been lying in her bed with the television on. *She had asked this surveyor to turn it off. *She used to keep herself very busy and was always active. *She had not been participating in activities as she did not feel like it. *She stated "I'm lonely" and "I just have to accept my situation." *She did not know who the social worker was when asked.</p>	F 250	<p>F250 Medically related Social Services</p> <p>Resident #1 and #4 have had a social service completed and interventions have been reviewed and revised for each resident.</p>		

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F 250	<p>Continued From page 15</p> <p>Review of resident 1's 6/19/14 and 11/13/14 Minimum Data Set (MDS) assessments revealed she had been mildly depressed. Her cognition (thinking) was moderately impaired.</p> <p>Review of resident 1's 11/13/14 psychosocial progress note revealed: *The licensed social worker (LSW) had completed the form. *Under the mood and behavior section she had written: -"Resident indicated feeling down, trouble sleeping, feeling tired/having little energy and being fidgety/restless." -"Resident's mood score has declined slightly." -"Will monitor for mental health referral as warranted."</p> <p>Review of resident 1's 11/20/14 care plan revealed: *She had an admission date of 3/12/14. *Mood had been identified as a concern. *Interventions listed included: -"Encourage me to get involved in activities related to my interests," however no interests were listed. -"Encourage me to stay awake and be active during the day so I can sleep better at night." -"Help me to keep in contact with family and friends." There was nothing identified as to how often or who those people were. -"Introduce me to others with similar interests," however no interests were listed. -"Monitor for mental health referral as warranted." There were no specific mood or behaviors listed to monitor. -"Please give me my medications that help with my depression and manage any side effects,"</p>	F 250	<p>Residents residing in the facility requiring social services interventions and follow up have the potential to be affected. No further concerns were identified.</p> <p>A review of these residents has been completed by the social worker and appropriate follow up and documentation has been completed. <i>x see page 17. KASDDH/MF</i></p> <p>Executive Director and Social Service Director have reviewed the job responsibility of the Social Service position as it relates to resident needs, follow-up and documentation of process. Documentation Techniques, Social History Resources, Psychosocial History, Assessment Form, Interdisciplinary Care Plan, Social Services Progress Note, Social Services Notes, Discharge Plan, Discharge Summary and Post-Discharge Plan of Care from the Social Services Manual were utilized.</p> <p>Executive Director or designee will review social service progress notes weekly x 4 weeks then monthly x 2 months to ensure resident's needs are being met.</p>	

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F 250	<p>Continued From page 16 however no side effects were listed. -"Please tell my doctor if my symptoms are not improving to see if I need a change in my medication," however no symptoms were listed. -"Take the time to discuss my feelings when I'm feeling sad."</p> <p>Review of the LSW progress notes for resident 1 revealed: *There had been one note written after the 11/13/14 psychosocial progress note mentioned above. *That note had been dated 11/25/14 and titled "Quality Care Meeting Summary." *The information from the psychosocial progress note had been put in to that note. *There had been no other documentation from the LSW of interventions attempted to help with resident 1's depression. *There had been no documentation that monitoring her mental health had occurred. *There had been no referral to mental health services.</p> <p>The LSW was unavailable to be interviewed during the survey.</p> <p>Interview on 12/18/14 at 2:30 p.m. with the administrator, director of nursing (DON), and the nurse consultant revealed: *They had contacted the LSW regarding documentation for resident 1. *What they had provided was all the documentation the LSW had.</p> <p>Surveyor: 35121 Preceptor: 33488 2. Review of resident 4's medical record revealed:</p>	F 250	<p>Executive Director will report results of the audits and they will be reviewed by the QAPI committee monthly for further recommendations.</p> <p><i>* (continued from page 16) Social services can report to identify residents scoring above 15 on PHQ-9 mood interview, to assess which residents may be at risk for depression. Those scoring 10 or higher are either working with Deer Oaks mental health or refused. KESDDOH/MF</i></p>	1/20/15

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F 250	<p>Continued From page 17</p> <p>*He had a score of fifteen out of fifteen on the Brief Interview for Mental Status assessment (BIMS).</p> <p>*A BIMS score of fifteen showed no cognitive (mental) impairment.</p> <p>*He had voiced to the LSW his concerns of:</p> <ul style="list-style-type: none"> <li>-Dissatisfaction of having had to change rooms and not being allowed to return to his old room.</li> <li>-New room had been cold.</li> <li>-Not getting dressing changes when he requested a dressing change.</li> </ul> <p>*LSW had documented:</p> <ul style="list-style-type: none"> <li>-The resident would have to remain in the new room for bed management purposes.</li> <li>-He refused to get dressed in warmer clothing.</li> <li>-Maintenance was aware of temperature concern and expected a repairman that day.</li> <li>-Room assignments would be re-evaluated the next week.</li> <li>-She "will continue to monitor."</li> <li>-There had been no documentation of monitoring or follow-up by the LSW regarding the above concerns.</li> </ul> <p>*Review of the resident's quality care meeting summary sections completed by the LSW and LSW notes revealed no mention of the resident's concern with his room change, room temperature, or dressing changes.</p> <p>Refer to F166, finding 1.</p> <p>Surveyor: 32335</p> <p>3. Review of the 2/4/13 LSW job description revealed the social worker was to:</p> <p>**Assist in the identification of and to provide for each resident's social, emotional, and psychological needs, and the continuing development of the resident's full potential during his/her stay at the facility."</p>	F 250			

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F 250	Continued From page 18 **Document progress notes, which relate to each resident's care plan when necessary and within policy timeframe's." **Implement staff approaches that address problems, needs or concerns and periodically review." **Evaluate the effectiveness of the staff approaches." **Evaluate changes in the mental and psychosocial assessment."	F 250		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on observation and interview, the provider failed to ensure bathrooms, sinks, and floors were kept clean in seven of eight randomly observed resident rooms and lighting issues were addressed in three of eight resident bathrooms. Findings include:  1. Observation on 12/16/14 at 11:00 a.m. in the 100, 200, and 300 Wings revealed: *There were multiple sinks that had brownish residue inside the sink. *Floors in some of the residents bathrooms were soiled and were unclean. *One bathroom had dried on feces (stool) on the toilet, and there was a used piece of toilet paper lying on the floor in a resident bathroom with feces on the toilet paper.	F 253	<p><i>* New light bulbs were ordered for 20 rooms. (2 were completed on 1/15/15). The balance will be received and installed by 4/15/15. KES/DROH/ME</i></p> <p>F 253 – Housekeeping &amp; Maintenance Services</p> <p>Contracted housekeeping service brought in staff from other sites to complete deep cleaning of all resident rooms and living areas.</p> <p>Contracted housekeeping service will provide orientation to their staff to avoid future occurrence.</p> <p>Executive Director or designee in conjunction with Housekeeping Manager will complete a housekeeping audit weekly x 4 weeks then monthly x 2 months to ensure resident's needs are being met. Executive Director will report results of the audits and they will be reviewed by the QAPI</p>	

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F 253	<p>Continued From page 19</p> <p>*One bathroom had bedpans lying directly on the floor beside the toilet.</p> <p>Interview on 12/16/14 at 11:16 a.m. with housekeeper Q regarding her hours and work routine revealed: *She had only been employed with the company for two weeks. *She was the only housekeeper, and it had been very difficult for her to get all her work completed in eight hours. *Her scheduled shift was 7:00 a.m. to 2:30 p.m., but she had stayed until 4:00 p.m. most days to get all her work completed.</p> <p>Interview on 12/16/14 at 12:15 p.m. with the district manager for housekeeping and laundry H regarding the above observations revealed: *(Name of the company) had taken over on November 16, 2014. *She had confirmed the provider had been short staffed for approximately three weeks. -Two housekeepers had been out on extended leave. -One housekeeper had felt overwhelmed and had quit without notice. *There was only housekeeper Q that was available to work. *The other housekeeper was working in laundry because of staffing issues.</p> <p>Interview and review on 12/16/14 at 4:00 p.m. of housekeeper Q's employee file with district manager H revealed: *She had started her employment two weeks ago. *She had not been properly trained prior to working independently. *Housekeeper Q should not have been working independently.</p>	F 253	committee monthly for further recommendations.	1/20/15
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F 253	Continued From page 20 *Agreed the appropriate and thorough cleaning of the residents' rooms and bathrooms were not being completed due to staffing issues.  Interview on 12/17/14 at 4:00 p.m. with the maintenance supervisor regarding the cleaning of the resident rooms, bathrooms, and the lighting in three randomly observed resident rooms revealed he confirmed the above observations. He agreed the rooms, bathrooms, and sinks needed some work. He would also look into those resident rooms where the bathroom lighting was dim. The maintenance supervisor was notified of the rooms that were identified during the random observation on 12/16/14 at 11:00 a.m.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	<i>See next page</i>	

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F 279	<p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to develop a thorough temporary care plan for one of four newly admitted sampled residents (6). Findings include:</p> <p>1. Review of resident 6's medical record revealed: *He was admitted on 12/12/14 with diagnoses of kidney disease needing dialysis, diabetes, high blood pressure, chronic pain, depression, Clostridium difficile (C-diff) (a bacterial infection found in the intestinal tract) and a healing clavicle (collarbone) fracture. *His health history documentation from the hospital revealed he: -Had a recent tunnel catheter (placed temporarily in his chest so he could receive dialysis) on 12/5/14. -He had an AV fistula in his left thigh (a more permanent dialysis access made from connecting arteries to veins). -His fistula had become clotted during his hospital stay and had required recent surgical intervention to declot it.</p> <p>Review of resident 6's initial nursing assessment dated 12/12/14 revealed: *Section A documentation showed he: -Had a diagnosis of end stage renal (kidney) disease and needed dialysis. -Experienced shortness of breath and used respiratory (lung) medications. -Had a drug resistant infection (infection not</p>	F 279	<p>F 279 – Develop Comprehensive Care Plans</p> <p>Resident #6 was reviewed and a temporary care plan was implemented as soon as the concern was brought forward.</p> <p>Newly admitted residents who have not had a comprehensive care plan completed have the potential to be affected in a similar manner. An audit was completed residents admitted after December 17, 2014 to ensure a temporary care plan was in place that met the resident's</p>	
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F 279	<p>Continued From page 22 specified).</p> <p>*Section B documentation showed he:</p> <ul style="list-style-type: none"> <li>-Had a tunnel catheter.</li> <li>-There was no mention of his AV fistula on the physical assessment picture graph.</li> </ul> <p>*Section C through G documentation showed he:</p> <ul style="list-style-type: none"> <li>-Had a history of high blood pressure and chest pain.</li> <li>-Had C-diff.</li> <li>-Was receiving dialysis.</li> <li>-Dialysis access site information had been left blank.</li> <li>-Pivot (turn) transferred with limited assistance of two staff.</li> </ul> <p>*Section H through M documentation showed he:</p> <ul style="list-style-type: none"> <li>-Was at risk for dehydration related to an infectious process and use of a cardiovascular medication.</li> <li>-Had one to two falls within the past three months.</li> <li>-Was incontinent.</li> <li>-Had lower extremity weakness and required assistive devices.</li> </ul> <p>*Sections N through O documentation showed he:</p> <ul style="list-style-type: none"> <li>-Had "no pain."</li> <li>-Location was documented as in the shoulder.</li> <li>-Described his pain as aching.</li> <li>-Had hydrocodone (narcotic pain medication) to relieve his pain which was check marked effective in treatment.</li> </ul> <p>Review of resident 6's current 12/12/14 temporary care plan revealed his:</p> <ul style="list-style-type: none"> <li>*Urinary incontinence risk page described him as incontinent needing a two person pivot with assistance to transfer.</li> <li>*Pain risk page had pain checked but did not state where that pain was located.</li> </ul>	F 279	<p>immediate care needs. No additional concerns were identified</p> <p>Reeducation was completed to licensed nurses regarding temporary care plans and completion expectations.</p> <p>Director of Nursing Services will review new admissions weekly x 4 weeks to ensure that initial care plans were implemented and accurate. Director of Nursing Services will report results of the audits and they will be reviewed by the QAPI committee for further recommendations monthly.</p>	<p>2011/15 KJSDH/ME</p> <p>1/20/15</p>

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F 279	<p>Continued From page 23</p> <p>*Alteration kidney function-hemodialysis page showed:</p> <ul style="list-style-type: none"> <li>-He was at risk for infection at the fistula site.</li> <li>-Had fluid limitations related to renal access but had not clarified how much fluid he could have.</li> <li>-Interventions check marked were: <ul style="list-style-type: none"> <li>a. "Observe for clinical signs of infection at the fistula sight" but no mention of where that was located nor documentation he also had a tunnel catheter.</li> <li>b. Do not take a blood pressure on the arm with the fistula was check marked</li> </ul> </li> <li>-His AV fistula was located in his left thigh.</li> <li>c. Encourage resident to not lie or sleep on arm with fistula.</li> <li>d. Monitor blood pressure (BP) daily. <ul style="list-style-type: none"> <li>-No records could be found at the time of the survey in the electronic medical record under Vitals which showed that BPs had been done.</li> </ul> </li> <li>e. Educate resident to follow dietary/fluid management program. <ul style="list-style-type: none"> <li>-No mention was made of what the program included or what his restrictions were for fluid.</li> </ul> </li> </ul> <p>*Diabetes page documentation showed:</p> <ul style="list-style-type: none"> <li>-He had type II diabetes.</li> <li>-Interventions check marked were: <ul style="list-style-type: none"> <li>a. Medications per medical doctor (MD) orders.</li> <li>b. Insulin per MD orders.</li> <li>c. Blood sugars per MD orders and as needed.</li> <li>d. Monitor for signs and symptoms of low blood sugar.</li> </ul> </li> <li>*There were no orders for any diabetes medication.</li> <li>*It was unknown if his diabetes had been diet controlled or required medication.</li> <li>*There was no mention of the resident having C-diff infection or what precautions were needed for staff and visitors.</li> <li>*There was no mention of the resident's</li> </ul>	F 279			

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F 279	<p>Continued From page 24 respiratory status on the temporary care plan.</p> <p>Interview on 12/16/14 at 5:30 p.m. with registered nurse F regarding resident 6 revealed: *She was new to the facility and had worked there "about two months." *She checked his blood sugar four times per day. *She had never administered any diabetes medication to the resident. *She had not monitored his tunnel catheter or his AV fistula in his left thigh as it had not been on his treatment plan in the electronic medical record. *She was aware he had C-diff but could not tell me what precautions that required.</p> <p>Interview on 12/16/14 at 6:00 p.m. with certified nursing assistant G revealed: *She would use the stand-aide (lift used to transfer a resident from one surface to another) to toilet the resident. *He was unable to stand on his own to turn with assistance. *She was aware he had C-diff but was unsure what exact precautions were needed for his care. *He had been incontinent of stool since his admission on 12/12/14.</p> <p>Interview on 12/19/14 at 1:30 p.m. with the director of nursing (DON) and administrator regarding resident 6's care plan revealed they agreed his care plan was not specific to the resident's needs and level of care.</p> <p>Review of the provider's August 2012 Isolation-Categories of Transmission-Based Precautions policy revealed the resident's care plan must indicate the type of precautions implemented for the resident.</p>	F 279			

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F 279	Continued From page 25 The provider had no specific care plan policy at the time of the survey as reported by the DON.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 33488 A. Based on observation, interview, record review, and policy review, the provider failed to: *Monitor, assess, and intervene, when medications had not been administered as ordered for one of one sampled resident (6). *Monitor an arteriovenous (AV) fistula (a long term dialysis access made from connecting an artery to a vein) and a tunnel catheter (catheter placed under the skin in the chest to allow for short term dialysis) for one of three newly admitted residents (6) with dialysis accesses. *Advise the dialysis center of one or two residents (6) who recieved dialysis treatment of an infection that required contact precautions. Findings include:  1. Review of resident 6's medical record revealed: *He was admitted on 12/12/14 with diagnoses of kidney disease needing dialysis, diabetes, high blood pressure, chronic pain, depression, Clostridium difficile (C-diff) (a bacterial infection found in the intestinal tract), and a healing clavicle (collarbone) fracture. *His current medication administration record (MAR) had several "7s" marked on December 13	F 281	F 281 Services Provided Meet Professional Standards  Medications for resident #6 have been obtained.  <del>*NO</del> Tunnel catheter monitoring was added to resident's treatment administration record.  Residents residing in the facility who take medications have the potential to be affected in a similar manner.  Residents residing in the facility who receive tunnel catheter and AV fistula care have the potential to be affected in a similar manner.  An audit was completed to ensure residents medications were available and being administered as ordered. Two additional med omissions were identified and physicians notified.	

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F 281	<p>Continued From page 26 and 15.</p> <p>*The Charting Codes/Follow Up Codes legend found on the bottom left corner of the MAR revealed "7" to refer to "Other/See Nurses Notes".</p> <p>*His health history documentation from the hospital revealed he:</p> <ul style="list-style-type: none"> <li>-Was receiving dialysis treatment.</li> <li>-Had a recent tunnel catheter (placed temporarily in his chest so he could receive dialysis) on 12/5/14.</li> <li>-He had an AV fistula in his left thigh (a more permanent dialysis access made from connecting arteries to veins).</li> <li>-His fistula had become blocked during his hospital stay and required recent surgical intervention to unblock it.</li> </ul> <p>Review of the Progress Notes documented by nursing revealed:</p> <ul style="list-style-type: none"> <li>*Two entries labeled "e-MAR-medication administration note" both made on December 13, 2014 at 4:22 a.m. of "This medication has not arrived yet."</li> <li>*Two entries labeled "e-MAR-medication administration note" dated 12/14/14 at 11:33 p.m. of "unavailable medication."</li> <li>*Two entries labeled "e-MAR-medication administration note" dated 12/15/14 at 5:03 a.m. and 5:04 a.m. of "unavailable medication."</li> <li>*No assessment had been documented in the nurses notes regarding the resident's blood pressure on 12/15/14 in the absence of his medication .</li> <li>*No blood pressure monitoring had been documented in the electronic medical record when the resident had not received his blood pressure medication on 12/15/14.</li> <li>*No assessment or monitoring had been</li> </ul>	F 281	<p>An audit was completed to ensure residents who have an AV fistula or tunnel catheter have appropriate monitoring on the treatment administration record. There was a second resident with one but in auditing his care plan, it was listed.</p> <p>* ON 01/07/15 KLS/DDH/MF Licensed Nursing Staff will be educated on the process when not receiving medications from primary pharmacy.</p> <p>* ON 01/07/15 KLS/DDH/MF Licensed Nursing Staff will be reeducated on the Golden Living Dialysis Guideline.</p> <p>.Director of Nursing or designee will complete daily audits x 4 weeks, weekly x 2 months to ensure medications were administered as ordered and that fistula/tunnel catheter checks have been completed for dialysis residents. DON will report results of the audits and they will be reviewed by the QAPI committee for further recommendations monthly.</p>	1/20/15
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F 281	<p>Continued From page 27</p> <p>documented in the nurses notes regarding his pain, respiratory condition, urinary continence, depression, or temperature.</p> <p>Interview on 12/17/14 at 11:45 a.m. with licensed practical nurse (LPN) K regarding the above MAR revealed: *She had worked December 13 and 14, 2014. *She stated those medications referenced had not arrived yet from the pharmacy which was located out-of-state. *Those medications not given and check marked as "7" on the MAR were not available in the AlixaRx (automated medication dispensing machine) at that time.</p> <p>Interview on 12/18/14 at 9:20 a.m. with LPN C regarding resident 6's MAR revealed medications marked with a "7" on the MAR were unavailable to be administered. Those medications were: *Atrac-Tain cream- (for dry skin) to be given three times per day but had not been given twice on December 13, once on December 14, and twice on December 15, 2014 *Flagyl- (for treat C-diff) to have been given three times per day but had not been given on December 15, 2014. *Amoxicillin- (antibiotic for the resident's urinary tract infection) was to be given one time per day but had not been given on December 15, 2014. *Celexa- (for depression) to be given one time per day but had not been given on December 15, 2014 *Carvedilol- (for high blood pressure) to be given two times per day but had not been given on December 15, 2014. *Pulmicort- (breathing treatment) to be given two times per day had not been given the mornings of December 13 and 15.</p>	F 281			

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F 281	<p>Continued From page 28</p> <p>*Flomax- (used to treat an enlarged prostate) was to be given one time per day but had not been given on December 15, 2014.</p> <p>*Lidocaine patch- (pain reliever) was to be applied one time per day had not been given on December 15, 2014, nor had the previous days medication patch been removed.</p> <p>*Nephrocaps capsule- (helps the kidneys function better) to be given one time per day but had not been given on December 15th, 2014.</p> <p>*Gabapentin- (for nerve pain) to be given four times per day had not been given on December 15, 2014</p> <p>*She had reported the unavailable medications to the director of nursing (DON) and reported it to the oncoming shift as instructed.</p> <p>*She had not notified the physician of the error.</p> <p>Interview on 12/18/14 at 1:30 p.m. with the director of nursing (DON) and administrator regarding the above medications for resident 6 revealed:</p> <p>*The DON stated LPN C had not notified her of the unavailable medications for resident 6.</p> <p>*It was their expectation the physician called and appropriate measures would be taken to ensure the resident's safety and health.</p> <p>*They both had agreed there had been no documentation to support nursing staff appropriately monitored, assessed or intervened regarding the resident's health following the above omission of medications.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 583 revealed, "When an error (with medication) occurs, the patient's safety and well-being become the top priority. The nurse first assesses and examines the patient's condition and notifies</p>	F 281		

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F 281	<p>Continued From page 29</p> <p>the health care provider of the incident as soon as possible."</p> <p>2. Review of resident 6's current 12/12/14 temporary care plan revealed: *He was at risk for infection at the fistula site. *He had fluid limitations related to renal access but had not been clarified how much fluid he could have. *Interventions check marked were: -"Observe for clinical signs of infection at the fistula sight" but no mention of where that was located or that he also had a tunnel catheter had been documented. -Don't take a blood pressure on the arm with the fistula but his AV fistula was located in his left thigh. -Encourage resident to not lie or sleep on arm with fistula. -Monitor blood pressure (BP) daily. -Educate resident to follow dietary/fluid management program." *There were no records that showed BP's had been taken since his initial nursing assessment upon admission through 12/18/14 at 11:00 a.m. *There was no mention of what his diet program included or how much fluid he could have.</p> <p>Review of resident 6's 12/12/14 initial nursing assessment revealed: *Section B documentation showed he: -Had a tunnel catheter. -There was no mention of his AV fistula on the physical assessment picture graph. -Had a baseline blood pressure documented of 90/50 millimeter of mercury (mm/Hg). *Section C through G documentation showed he: -Had a history of high blood pressure. -Dialysis access site information had been left</p>	F 281		

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F 281	<p>Continued From page 30 blank.</p> <p>Interview on 12/16/14 at 5:30 p.m. with registered nurse (RN) F regarding resident 6 revealed: *She was new to the facility and had worked there "about two months." *She had not been aware of his tunnel catheter or AV fistula. *She had known he went to dialysis. *She had not monitored his tunnel catheter located in his chest or his AV fistula located in his left thigh. *She was unaware of the need to monitor those access sites. **If I have to do it, it shows up on my TAR (treatment administration record)."</p> <p>Review of resident 6's TAR revealed: *An order dated 12/16/14 to begin on 12/17/14 was placed on the treatment administration record at 10:47 a.m. by an unidentified staff member. *Staff were to "check access site every day fistula/graft/catheter for signs and symptoms of infection such as redness, swelling, pain, drainage, elevated temp, body chills." *Staff were to "monitor thrill (vibration) and bruit (a swishing noise) in the fistula daily."</p> <p>Interview on 12/18/14 at 1:30 p.m. with the DON and administrator regarding resident 6's tunnel catheter and AV fistula revealed: *It had been their expectation appropriate monitoring of his fistula and tunnel catheter by nursing staff should have occurred upon admission and thereafter. *His newly unblocked fistula and tunnel catheter could have experienced complications from lack of monitoring.</p>	F 281		
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F 281	<p>Continued From page 31</p> <p>Review of Donna D. Ignatavicius and M. Linda Workman, Medical-Surgical Nursing, 7th Ed., St. Louis, MO 2013, page 1562, revealed caring for a resident with an AV fistula should involve daily:</p> <ul style="list-style-type: none"> <li>*Palpating (feel) for thrills and listening for a bruit.</li> <li>*Assessing distal (lower leg and foot) pulses for circulation in the leg with the access.</li> <li>*Checking for bleeding.</li> <li>*Assessing for infection.</li> </ul> <p>Review of the provider's January 2011 Dialysis Guideline revealed:</p> <ul style="list-style-type: none"> <li>**Check fistula for bruit and a thrill. This must be done daily.</li> <li>*Blood pressure checks as needed and daily.</li> <li>*Check for signs and symptoms of infection daily.</li> <li>*Compliance included:               <ul style="list-style-type: none"> <li>-Daily documentation on (medication administration record (MAR)/TAR.</li> <li>-Emergency protocol for fistula/graft/external catheter in place.</li> <li>-Care plan inclusive of safety, assessment, emergency measures in place."</li> </ul> </li> </ul> <p>3. Review of resident 6's medical record revealed he:</p> <ul style="list-style-type: none"> <li>*Was admitted from a hospital on 12/12/14.</li> <li>*Had an active C-diff infection.</li> <li>*Was incontinent (no control over bodily functions involving his bowel movements and urine).</li> <li>*Received dialysis from an outside center (not in the facility).</li> </ul> <p>Interview on 12/17/14 at 12:55 p.m. with RN T from the outpatient dialysis center regarding resident 6's dialysis revealed:</p> <ul style="list-style-type: none"> <li>*His first day of dialysis at the center had been Monday, 12/15/14.</li> </ul>	F 281		
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F 281	<p>Continued From page 32</p> <p>*The dialysis center had not been made aware of his active C-diff infection from the provider prior to him receiving dialysis treatment.</p> <p>*They were unaware the resident was incontinent.</p> <p>*They were not equipped with undergarments if the resident had become incontinent while he was in their facility.</p> <p>**"We will start contact precautions right away."</p> <p>Interview on 12/18/14 at 1:30 p.m. with the DON revealed she:</p> <p>*Stated "He had received dialysis before he even got to our facility so they (the dialysis center) knew."</p> <p>*Stated "We send them a report on medications. His Flagyl is on there and he's on that for C-diff."</p> <p>*Was unaware he was receiving dialysis since his admission to the facility from the outpatient dialysis center and not from the hospital that he had been admitted from.</p> <p>*Agreed the outpatient dialysis center should have been notified in advance of treatment the resident had C-diff.</p> <p>*Agreed there needed to be better communication with the outpatient dialysis center.</p> <p>Review of the provider's January 2011 Dialysis Guideline revealed:</p> <p>*Communication is essential for continuity of care.</p> <p>*Education surrounding care and unique needs of the resident was also important.</p> <p>*Communication should have included any changes in condition or mood.</p> <p>Review of the provider's August 2012 Isolation-Categories of Transmission-Based Precautions policy revealed:</p> <p>**"If the resident is transported to another facility,</p>	F 281		
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F 281	<p>Continued From page 33 the Infection Preventionist (or designee) will notify the facility of the type of precautions the resident is on and the type of infection." **"The facility is also responsible for notifying transport staff of residents that require special care due to infectious conditions."</p> <p>Surveyor: 35120 Preceptor: 30170 B. Based on observation, record review, and interview, the provider failed to assess, monitor, and document urinary output for one of one sampled resident (8) who had cystoscopy procedure (used to see inside the urinary bladder and urethra [tube that carries urine from the bladder to the outside of the body]) with a surgical right ureteral stent placement (a thin, flexible tube threaded into the ureter to help urine drain from the kidney to the bladder or to an outside collection system). Findings include:</p> <p>1. Random observation from 12/16/14 through 12/18/14 revealed resident 8 had a Foley catheter (tube inserted into the bladder to drain urine into a collection system).</p> <p>Review of resident 8's medical record revealed: *She was admitted on 2/25/14. *She was hospitalized from 11/22/14 through 12/3/14. During her hospitalization she had a surgical procedure done on 11/30/14. *She was readmitted on 12/3/14. *Her diagnoses included: -Right hydronephrosis (kidney swelling). -A large renal (kidney) cyst (tumor or mass). -Clostridium difficile (infectious diarrhea). -Urinary tract infection (UTI). *On 12/9/14 (six days after readmission from the hospital) her weekly skin assessment stated she</p>	F 281	<p>* For Resident #8 we could not address as she passed away on 12/23/14. As this can affect any resident with a catheter, the process was reviewed. There are three residents with catheters in the facility. The plan is to record output for residents with catheters and care plans have been updated. KEY/DDH/ME</p>	
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F 281	<p>Continued From page 34 had a Foley catheter. *Her 9/3/14 individualized care plan had no documentation of her Foley catheter. *On 12/10/14 at 6:45 a.m. a nursing progress note revealed there was "very low urine output of around 25 ml."</p> <p>Review of resident 8's Intake (I) and Output (O) By Day Report revealed there was no oral intake or urine output documented on her I and O flowsheet.</p> <p>Interview on 12/18/14 at 8:30 a.m. with certified nursing assistant (CNA) M revealed the charting was done on the Kiosk (electronic charting). It contained information about the care of her Foley catheter and amount of urine drained from the urine bag.</p> <p>Interview on 12/18/14 at 9:05 a.m. with the director of nursing (DON) revealed either the DON, registered nurse (RN) B, or the Minimum Data Set (MDS) coordinator were responsible for entering the information regarding resident 8's Foley catheter on the Kiosk for the CNAs to document.</p> <p>Interview on 12/18/14 at 9:10 a.m. with MDS coordinator R regarding resident 8 revealed: *She had returned from the hospital on 12/9/14 (review of the resident's hospital discharge summary documented a discharge date of 12/3/14). *There was no information entered into the Kiosk for the CNAs to document on the urine output. *She had not felt nine days since the resident had been readmitted was a concern regarding lack of documentation about her urine output. *There was no documentation of the Foley</p>	F 281		
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F 281	<p>Continued From page 35</p> <p>catheter on the resident's care plan.</p> <p>*CNAs were supposed to have been informed of the Foley catheter by a verbal report from the nurses.</p> <p>Interview on 12/18/14 at 9:30 a.m. with the DON revealed: *It was not a requirement to track the amount of output on Foley catheters. *She had not felt the urine output needed to be recorded, but staff had been emptying the bag on each shift.</p> <p>Interview on 12/18/14 at 9:45 a.m. with RN B revealed there should have been information placed into the Kiosk so the CNAs could document the urine output and care provided.</p> <p>Interview on 12/18/14 at 3:40 p.m. with the DON and the nurse consultant revealed: *Measuring Foley catheter output was not necessary if there was not a physician's order. *Resident 8 was completely mobile (no restrictions in movement) but at times she could not move by herself and needed assistance. *The provider had no I and O or Foley catheter policy. *The nurse consultant stated the provider would use Potter and Perry and other references for professional nursing standards.</p> <p>Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, Mo., 2005, pp 206-207 revealed: **The nursing process is a critical thinking process that professional nurses use to apply the best available evidence to caregiving and promoting human functions and responses to health and illness (American Nurses Association,</p>	F 281		

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F 281	Continued From page 36 2010). The nursing process is also a standard of practice, which, when followed correctly, protects nurses against legal problems related to nursing care." **Assessment is the deliberate and systematic collection of information about a patient to determine his or her current and past health and functional status and his or her present and past coping patterns (Carpenito-Moyet, 2009)."  Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, Mo., 2005, pp 1052 throug 1062, revealed: **Assessment of urine involves measuring patients fluid I&O and observing characteristics of their urine. A change in urine volume is a significant indicator of fluid alterations or kidney disease. Report any extreme increase or decrease in urine volume. An individual's daily output generally ranges from 1200 to 1500 mL of urine (Hall, 2011). An hourly output of less than 30 mL for more than 2 consecutive hours is cause for concern." **After patient's return assess the vital signs and the characteristics of urine; monitor I&O; encourage fluids; and observe for fever, dysuria, and pain in suprapubic region." **All patients with catheters should have a daily intake of 2000 to 2500 mL if permitted. Patients can do this through oral intake or intravenous infusion. A high fluid intake produces a large volume of urine that flushes the bladder and keeps catheter tubing free of sediment."	F 281	*The DNS will monitor that residents with catheters have out put documented weekly times 4 weeks, then monthly times two months. The DNS will report the results of the audits and they will be reviewed by the QAPI committee for further recommendations monthly. KGS/DDH/MF	
F 314 SS=G	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	F 314	* Specific interventions were an air mattress, to reposition with cares and Tegaderm hydrocolloid every 2 days. KGS/DDH/MF F314 Treatment/Services to prevent/heal pressure sores Resident #8 skin has been evaluated and interventions have been put in place to prevent further skin decline. ✕	

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F 314	<p>Continued From page 37</p> <p>who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30170</p> <p>Surveyor: 35120 Preceptor: 30170 Based on observation, record review, interview, and policy review, the provider failed to put appropriate interventions in place to prevent pressure ulcers (wound over a bony area usually from sitting or lying in same position over an extended period of time) from developing for one of one sampled resident (8) who was dependent on staff for bed mobility (requires physical assistance to reposition in bed) and who had a history of pressure ulcers. Findings include:</p> <p>1. Observation from 12/17/14 through 12/18/14 of resident 8 revealed at the following times: *She was lying on her back in bed on: *12/17/14 from 9:45 a.m. to 11:30 a.m. *12/17/14 from 11:30 a.m. to 12:32 p.m. *12/17/14 at 3:20 p.m. *12/18/14 at 9:40 a.m. to 1:10 p.m. *12/18/14 at 3:30 p.m.</p> <p>Observation on 12/18/14 at 2:55 p.m. revealed registered nurse (RN) B during a skin assessment had to physically reposition the resident onto her side to inspect her sacral area</p>	F 314	<p>Residents residing in the facility who are at risk for developing pressure ulcers have the potential to be affected in a similar manner.</p> <p>Utilizing the most recent skin assessments, plans will be completed for residents currently residing in the facility and skin concerns will be documented on the wound evaluation flow record as indicated in the Golden Living Skin Integrity Guidelines. Eleven weekly assessments had been missed but no additional skin issues identified. Wound flow sheets are present for all who have wounds. * See page 39. KC/SDDH/MF</p> <p>Reeducation will be completed to the nursing staff related to procedures of the Golden Living Skin Integrity Guidelines.</p> <p>Director of Nursing or designee will complete an audit of wound evaluation flow records weekly x 4 weeks and monthly x 2 months to ensure skin concerns have been appropriately documented and treatments are in place. Director of Nursing will report results of the audits and they will be reviewed during the monthly</p>		

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F 314	<p>Continued From page 38 (area on the lower back).</p> <p>Review of resident 8's medical record revealed she: *Was readmitted on 12/9/14 from the hospital. *Had diagnoses of: -Urinary incontinence (unable to control bladder) with a history of urinary retention (unable to empty bladder completely). -A history of pressure ulcers.</p> <p>Review of resident 8's 11/13/14 Minimum Data Set (MDS) assessment revealed she: -Needed extensive assistance of one person for bed mobility and toileting. -Needed minimal assistance of one person for transfers and hygiene. -Had a stage I or greater pressure ulcer that was unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough [yellow, tan, grey, green, or brown shed tissue] or eschar [tan, brown, black, or dead scab tissue] ). The area measured 2.0 centimeter (cm) X (by) 1.6 cm. -Had moisture associated skin damage (incontinence or perspiration in direct contact with the skin for extended periods of time). -Had not been placed on a turning and repositioning program.</p> <p>Review of resident 8's 12/10/14 MDS assessment revealed she: *Required extensive assistance of two staff for bed mobility, transfer, and toileting. *Needed extensive assistance of one staff person for personal hygiene. *Was at a risk of developing pressure ulcers. *Was coded as having one or more pressure ulcers at stage 1 (intact skin with non-blanchable</p>	F 314	<p>QAPI meeting for further recommendations.</p> <p><i>*(continued from page 39) Nursing staff checked Braden score on all residents to assess for high risk skin issues. Intervention was added to care plans for high risk residents. KJ/SDDOH/MF</i></p>	1/20/15

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F 314	<p>Continued From page 39</p> <p>redness of a localized area, usually over a bony prominence) or higher. *Had moisture associated skin damage.</p> <p>Review of the 12/9/14 weekly skin assessment for resident 8 revealed she: *Needed two staff assistance with bed mobility. *Was incontinent of loose stools related to clostridium difficile (bacteria that caused diarrhea). *Was to have been repositioned every two hours. *Had no bruises, abrasions, rashes, skin tears or pressure ulcers.</p> <p>Review of resident 8's 12/10/14 Braden scale (predicts pressure ulcer risk) revealed: *She had no impairments, responded to verbal commands, and could voice her discomfort or pain. *Her skin was usually dry. *She was chairfast (ability to walk was severely limited). *Her mobility was very limited, and she was unable to make frequent or significant changes in position independently. *Her nutrition was adequate. *She required moderate to maximum assistance in moving. *She required complete lifting without sliding against sheets and required frequent positioning with maximum assistance. *Her total score was sixteen, which put her at a mild risk for developing pressure ulcers.</p> <p>Interview on 12/17/14 at 3:10 p.m. with MDS coordinator R revealed resident 8 had a pressure ulcer on her toe, but it had healed two to three weeks ago.</p>	F 314			

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F 314	<p>Continued From page 40</p> <p>Interview on 12/18/14 at 2:25 p.m. with MDS coordinator R revealed the Braden scale coding in the moisture section was coded incorrectly as she was unaware the resident had diarrhea.</p> <p>Review of resident 8's 9/3/14 comprehensive care plan revealed she:</p> <ul style="list-style-type: none"> <li>*Was at risk for skin breakdown due to decreased mobility.</li> <li>*Was to have weekly skin assessments by a professional nurse and was to have skin monitored with morning and evening care.</li> <li>*Was to have been on a turning and repositioning program with care and toileting.</li> <li>*Required extensive assistance of two staff with use of 1/2 siderails and a trapeze for bed mobility.</li> <li>*Required assistance of two staff for toileting.</li> </ul> <p>Interview on 12/17/14 at 11:30 a.m. with certified nursing assistant (CNA) S regarding resident 8 revealed:</p> <ul style="list-style-type: none"> <li>*The resident required the use of a stand aid (mechanical lift used to move from place to place) to transfer in and out of bed.</li> <li>*She was not aware of any current pressure ulcers.</li> </ul> <p>Interview on 12/17/14 at 11:35 a.m. with licensed practical nurse (LPN) A regarding resident 8 revealed she:</p> <ul style="list-style-type: none"> <li>*Did not currently have any pressure ulcers or dressing changes.</li> <li>*Independently fed herself and was high functioning when she felt good.</li> <li>*Propelled herself and used her legs while in her wheelchair to move around.</li> <li>*Was able to stand and turn with one foot.</li> </ul> <p>Observation and interview on 12/18/14 at 1:10</p>	F 314		

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F 314	<p>Continued From page 41</p> <p>p.m. with RN L during resident 8's Foley catheter care revealed: *There was a purple darkened area on her sacral area (area at the bottom of the back). *She stated that was a new skin issue.</p> <p>Observation and interview on 12/18/14 at 2:55 p.m. with RN B regarding resident 8's skin concerns revealed: *He was unaware of any new pressure ulcers. *He confirmed the last weekly skin assessment had been done on 12/9/14. *There should have been a weekly skin assessment done on 12/16/14, and there was no documentation it had been completed. *The new pressure ulcer measured 1 cm x 1.2 cm, and he stated it was a stage II (partial thickness loss of dermis [skin] presenting as a shallow open ulcer with a red or pink wound bed) pressure ulcer. He stated the area was purple. *There was loose stool in her incontinent brief.</p> <p>Interview on 12/18/14 at 3:40 p.m. with the director of nursing (DON) regarding resident 8 revealed she: *Was unaware the resident had a pressure ulcer. *Reported she was completely mobile but at times she needed assistance. *An air mattress would be placed on the resident's bed.</p> <p>During the pre-exit interview on 12/18/14 at 6:30 p.m. with the administrator, DON, and nurse consultant revealed the provider would refer to Potter and Perry and other references regarding professional standards for nursing care.</p> <p>Review of the provider's 10/15/14 RN Assessment Coordinator job description</p>	F 314		

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F 314	<p>Continued From page 42 revealed:</p> <p>**Accurate and thorough completion of the MDS, Care Area Assessments (CAA), and Care Plans, in accordance with current federal and state regulations and guidelines that govern the process."</p> <p>**Acts as an in-house Case Manager demonstrating detailed knowledge of residents health status, critical thinking skills to develop an appropriate care pathway and timely communication of needed information to the resident, family, other health care professionals and third party payers."</p> <p>Review of the provider's revised November 2014 Skin Integrity policy revealed:</p> <p>**Living center develops a routine schedule to review patients/residents with wounds or at risk on a weekly basis and will document findings."</p> <p>**DNS or designee will be responsible to implement and monitor the skin integrity program. Wound status is monitored on a weekly basis."</p> <p>**Patients/residents will be observed by the CNA daily for reddened/open areas, edema of feet or sacrum. Changes will be reported to the licensed nurse and documented."</p> <p>**Determine care plans consistently implemented, evaluated and revised based on the needs of the resident."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2005, pp. 1176 through 1229, revealed:</p> <p>**Patients unable to independently change positions are at risk for pressure ulcer development."</p> <p>**The presence and duration of moisture on the skin increases the risk of ulcer formation.</p>	F 314		

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F 314	Continued From page 43 Moisture reduces the resistance of the skin to other physical factors such as pressure and/or shear force. Prolonged moisture softens skins, making it more susceptible to damage. Immobilized patients who are unable to perform their own hygiene needs depend on the nurse to keep the skin dry and intact. Skin moisture originates from wound drainage, excessive perspiration, and fecal or urinary incontinence." **"By identifying at-risk patients, you are able to put interventions into place for the at-risk patient and spare patients with little risk for pressure ulcer development the unnecessary and sometimes costly preventive treatment. Prevention and treatment of pressure ulcers are major nursing priorities." **"Preventing pressure ulcers is a priority in caring for patients and is not limited to patients with restrictions in mobility. Impaired skin integrity is not usually a problem in healthy, immobilized individuals but is a serious and potentially devastating problem in ill or debilitated patients. (WOCN, 2010)." **"Nurses constantly observe for skin integrity and identify at-risk patients from developing pressure sores. Nursing interventions focus on prevention." **"Nurses understand factors affecting pressure ulcer formation and wound healing." **"Nurses apply the WOCN (wound, ostomy, and continence nurse) standards for prevention of pressure sores and assessment for skin integrity, prevention and treatment."	F 314			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315	F 315 No Catheter, Prevent UTI, Restore Bladder		

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F 315	<p>Continued From page 44</p> <p>indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to complete bladder assessments for one of one sampled resident (1) who was on a toileting program. Findings include:</p> <p>1. Interview on 12/17/14 at 10:40 a.m. with resident 1 revealed: *She had to wait for staff to assist her to the bathroom. *She used the call light when she needed to go to the bathroom. *She had incontinent episodes, because she had to wait for staff. *She had not liked to have incontinent episodes, and it upset her when it occurred.</p> <p>Review of resident 1's 6/19/14 Minimum Data Set (MDS) assessment revealed she had: *Required extensive assistance from two staff to use the bathroom. *Been occasionally incontinent. *Been on a toileting program.</p> <p>Review of resident 1's 11/13/14 MDS assessment revealed she had: *Required extensive assistance from one staff person to use the bathroom.</p>	F 315	<p>Resident #1 has had a three day bladder evaluation completed <i>*done/ KEISSDOH/MF * see page 46. KEISSDOH/MF</i></p> <p>Resident residing in the facility that experience urinary incontinence have the potential to be affected in a similar manner.</p> <p>A bladder evaluation will be completed for residents that experience urinary incontinence and appropriate interventions will be initiated as appropriate. No additional concerns were identified.</p> <p>Nursing Staff will be reeducated <i>*on 1/15 KEISSDOH/MF</i> on the Golden Living Incontinence Management/Bladder Function Guideline.</p> <p>Director of Nursing or designee will complete an audit of newly admitted residents who experience urinary incontinence weekly x 4 weeks and monthly x 2 months to ensure bladder evaluations have been completed and interventions are in place. DON will report results of the audits and they will be reviewed during the monthly QAPI meeting for further recommendations.</p>	

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F 315	<p>Continued From page 45</p> <p>*Been frequently incontinent. *Been on a toileting program.</p> <p>Review of resident 1's 11/20/14 care plan revealed: *One staff person was to assist her with toileting. *Her scheduled toileting program was to assist her: -Upon arising. -Before and after meals and activities. -At bedtime and as needed during the night. *Staff were to evaluate for frequency and timing of incontinent episodes.</p> <p>Review of resident 1's medical record revealed there were no bladder assessments in the record that had been used to develop the toileting schedule. She had an admission date of 3/12/14.</p> <p>Interview on 12/18/14 at 2:30 p.m. and at 6:30 p.m. with the administrator, director of nursing (DON), and the nurse consultant regarding resident 1 revealed: *The DON stated the resident could use the bathroom without staff assistance. -That had contradicted the above MDS assessments and care plan documentation. *She was unaware the resident had gotten upset or felt bad when she was incontinent. *She was on a toileting program. *Per the nurse consultant staff were to use the "Bowel and Bladder Record Data Collection Tool" forms for three days to assess the residents urinary patterns. *Those assessments were then to be used to develop an individualized toileting program for the residents. *Those assessments had not been completed for the resident.</p>	F 315	<p>*(continued from page 45) Resident was continent of bowel and occasionally incontinent of urine. Resident is able to ambulate to restroom on her own but refuses. Resident is continent when prompted to restroom. Utilizing scheduled toileting and care plan updated. KJKDDH/MF</p>	

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F 315	Continued From page 46	F 315		
F 356 SS=D	<p>Review of the provider's 11/13/14 Incontinence Management/Bladder Function Guideline policy revealed:</p> <p>*The bladder management program was in place to help the resident control urination without a catheter whenever possible.</p> <p>*The Bowel and Bladder Tracking Tool should have been completed upon admission to identify any trends or patterns related to incontinence.</p> <p>*Upon completion of that tool and the Bladder Evaluation Form and the Bowel Evaluation Form the toileting program could be determined.</p> <p><b>483.30(e) POSTED NURSE STAFFING INFORMATION</b></p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>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: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>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:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request,</p>	F 356	<p><b>F 356 Posted Nurse Staffing Information</b></p> <p>Nurse Staffing Information has been posted since concern was brought forward.</p> <p>Residents residing in the facility have the potential to be affected. To ensure this does not occur again, the manager on duty has been assigned to complete the staff posting when the DON is not working. Department Directors were reeducated on Federal regulation 356 and how to complete the staff posting 1/5/15.</p>	

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F 356	<p>Continued From page 47</p> <p>make nurse staffing data available to the public 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: 30170 Based on observation, record review, interview, and policy review the provider failed to ensure nursing staff hours were consistently posted in an accessible area daily for two of two months. Findings include:</p> <p>1. Observation on 12/16/14 at 6:05 p.m. across from the nurses station revealed: *There was a clipboard with the census (the number of resident's in the facility) and the nursing hours. *There were nursing hours documented for the following days: -11/12/14. -11/18/14. -11/24/14. -11/25/14. -12/01/14. -12/16/14.</p> <p>Interview on 12/16/14 at 6:15 p.m. with the director of nursing regarding the posted nursing hours revealed she: *Was unsure why the hours were not posted for everyday. *Had been on vacation for the past two weeks. *Confirmed the nursing hours should have been</p>	F 356	<p>Executive Director or designee will audit nurse staffing posting daily audits x 4 weeks, weekly x 2 months to ensure nurse staffing hours are posted. Results of the audits will be reviewed by the QAPI committee for further recommendations.</p>	1/20/15

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F 356	Continued From page 48 posted daily.	F 356			
F 431 SS=D	<p>Review of the provider's 3/1/13 Nursing Staff Hours policy revealed: nursing staff hours would be posted in accordance with state and federal regulations in all facilities. The posting would be in a clear and readable format and posted in a prominent place readily accessible to residents and visitors.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>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.</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</p>	F 431	<p>F 431 Drug Records, Label, Store Drugs &amp; Biological</p> <p>The facility is unable to correct appropriate destruction of Fentanyl patch noted in the written deficiency.</p> <p>Residents residing in the facility who use Fentanyl patches have the potential to be affected in a similar manner.</p> <p>Residents residing in the facility who bring medications from home have the potential to be affected.</p> <p><i>* on 01/07/15 REEDEDHIME</i> Licensed Nursing Staff will be reeducated on the Alixa Disposal of Medications and Medication-Related Supplies and Controlled Substance Disposal and Medications Brought to the Facility by a Resident or Responsible Party policies.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435049</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - SALEM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 COLONIAL DRIVE SALEM, SD 57058</b>	
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F 431	<p>Continued From page 49</p> <p>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: 33488 Based on observation, interview, and record review, the provider failed to: *Appropriately store, reconcile, destroy, or refuse medications brought into the facility by a resident for one of fourteen sampled resident (14). *Appropriately store and limit access to discarded Fentanyl (controlled narcotic pain medication) patches. Findings include:</p> <p>1. Observation of the medication room on 12/17/14 at 3:20 p.m. and interview at that time with registered nurse (RN) F revealed: *A Zip-lock bag of medications belonging to resident 14 had been placed beside the refrigerator. *Inside the bag were the following bottles of medication: -Omeprazole (stomach acid reducer). -Lorazepam (a controlled antianxiety medication). -Lisinopril (heart or blood pressure medication). -Furosemide (diuretic). -Multivitamin. -Levetiracetam (anti-seizure medication). -Ondansetron (anti-nausea medication). -Thiamine (vitamin B). *She had not known what medications were in the bag.</p>	F 431	<p>Director of Nursing or designee will complete an audit of documentation for residents who receive Fentanyl patch weekly x 4 weeks and monthly x 2 months to ensure documentation of narcotic destruction was completed appropriately. DON will report results of the audits and they will be reviewed during the monthly QAPI meeting for further recommendations.</p> <p>Director of Nursing or designee will complete an audit of the medication room weekly x 4 weeks and monthly x 2 months to ensure medications brought to the facility have been reconciled, stored appropriately or destroyed as indicated by the policy. Director of Nursing will report results of the audits and they will be reviewed during the monthly QAPI meeting for further recommendations.</p>	1/20/15

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F 431	<p>Continued From page 50</p> <p>*They were kept in the medication room, because the resident had brought them into the facility after a vacation he had taken with his family in October 2014.</p> <p>*She was unsure why they were still there.</p> <p>*No record of reconciliation had been documented regarding the amounts of medication received.</p> <p>*She thought the facility nursing staff were waiting for notification from the pharmacy to see if it was ok to use them in the facility.</p> <p>*She agreed without medication reconciliation the provider had no way of knowing:</p> <ul style="list-style-type: none"> <li>-How much medication came into the facility.</li> <li>-How much medication remained in the bottle.</li> </ul> <p>2. Further interview with registered nurse (RN) F revealed:</p> <p>*Fentanyl patches were destroyed in the presence of another nurse into the sharps container.</p> <p>*When the sharps containers were full she would call maintenance.</p> <p>*Maintenance would come get the sharps container.</p> <p>*She had not known where maintenance took the containers for disposal.</p> <p>Observation and interview on 12/17/14 at 3:40 p.m. with licensed practical nurse (LPN) A regarding the destruction of used Fentanyl patches and the room the sharps containers were stored in revealed:</p> <p>*Nursing staff would remove the old patches and place them into the sharps containers witnessed by another nurse.</p> <p>*When the sharps containers had become full she would unlock it from her cart and take it downstairs to the basement to await destruction.</p>	F 431		

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F 431	<p>Continued From page 51</p> <ul style="list-style-type: none"> <li>*LPN A took this surveyor to the basement to an unsecured room where soiled laundry had been stored.</li> <li>*In the far corner of the room were cardboard boxes lined with red biohazard bags.</li> <li>*Inside those bags were multiple sharps containers awaiting destruction.</li> <li>*She stated any staff member had access to the room, as it also housed dirty laundry awaiting cleaning.</li> <li>*She agreed the sharps containers with used fentanyl patches were not limited to appropriate nursing staff.</li> <li>*She agreed that was an area of concern regarding possible diversion and theft of the sharps containers and the contents.</li> </ul> <p>3. Interview on 12/18/14 at 1:30 p.m. with the DON regarding the above two medication observations revealed:</p> <ul style="list-style-type: none"> <li>*She had been unaware of the lorazepam being stored in the zip-lock bag in the medication room.</li> <li>*She had not thought medications received from a resident needed to be reconciled.</li> <li>*She agreed there was a potential for diversion.</li> <li>*She had been aware of the storage of used Fentanyl patches.</li> </ul> <p>Review of the provider's November 2011 Medications Brought To the Facility By Physician's or Residents/Family members revealed the facility did not accept imported medications brought into the facility by a resident or family member.</p> <p>Review of the provider's November 2011 Medication Destruction policy revealed:</p> <ul style="list-style-type: none"> <li>*Medications should be "secured until destroyed."</li> <li>*Fentanyl patches should be flushed down the</li> </ul>	F 431		



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F 441	<p>Continued From page 53</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35120</p> <p>Surveyor: 35121</p> <p>Surveyor: 32335</p> <p>A. Based on observation, record review, interview, and policy review, the provider failed to: *Implement contact precautions (items used to protect oneself from coming into contact with a contagious illness or infection) for one of one sampled resident (6) with clostridium difficile (C-diff a bacteria that causes diarrhea and can be contagious). *Educate and train all staff including laundry and housekeeping contracted services regarding C-diff contact precautions and when to implement those precautions for two of two sampled residents (6 and 8) who staff stated had C-diff. *Use appropriate signage to alert visitors and staff of potential for contamination for one of one sampled resident (6).</p> <p>Findings Include:</p> <p>NOTICE:</p> <p>Notice of immediate jeopardy was given verbally to the director of nursing (DON) and the administrator on 12/17/14 at 9:45 a.m. They were asked to provide a plan of correction to the surveyors as soon as possible that included education to the staff regarding contact</p>	F 441	<p>Education will be provided to all staff (including contracted services) 12/17/14 (starting with all on staff now and as they arrive for work until all have received required education...education will be completed prior to the end of their next shift) on:</p> <p>Communication to specific residents and how this how this will be communicated It will be announced at standup</p> <p>A sign will be placed on the resident's door directing all to see nurse before entering. Nurse will give appropriate instructions for needed precautions.</p> <p>Cdiff risks Golden Living policy will be reviewed</p> <p>Cdiff protocols Golden Living policy will be reviewed</p> <p>Equipment that cannot be left in the room must be wiped down with approved bleach wipe and</p>	

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F 441	<p>Continued From page 54</p> <p>precautions, handwashing techniques, and utilizing appropriate signage for residents who could be contagious.</p> <p>PLAN:</p> <p>A plan of correction for education to the staff regarding contact precautions, handwashing techniques, and utilizing appropriate signage for residents who could be contagious was accepted on 12/17/14 at 4:00 p.m. The plan of correction also included screening of new admissions for possible isolation precautions.</p> <p>"For resident [6]: a new cart will be obtained with proper supplies that locks and will be placed outside the resident's room. Staff will be trained to manage appropriately 12/17/14 by Director of Clinical Education.</p> <p>Reviewed all residents for similar risk. Currently there is one resident with influenza and appropriate signage has been posted and staff will be educated as they come in to work on 12/17/14.</p> <p>New residents admitted to the facility will be screened for possible isolation precautions and staff will be notified accordingly.</p> <p>Education will be provided to all staff (including contracted services) 12/17/14 (starting with all on staff now and as they arrive for work until all have received required education...education will be completed prior to the end of their next shift) on:</p> <p>*Communication to specific residents and how this will be communicated.</p> <p>-It will be announced at stand up.</p> <p>-A sign will be placed on the resident's door directing all to see nurse before entering. Nurse will give appropriate instructions for needed precautions.</p>	F 441	<p>left wet for 5 minutes before using for another resident</p> <p>Handwashing competency will be completed</p> <p>Specific Education will be provided to housekeeping regarding disinfectant protocols by the Director Clinical Education or Housekeeping Manager before the end of their next shift.</p> <p>DCE or designee will audit that all residents with Cdif or other need for precautions have the proper signage weekly times 4 weeks.</p> <p>DCE or designee will observe staff entering said resident's room for proper procedures at least one time a week times 4 weeks. DNS will report results to QAPI and monitored from there.</p>	12/18/14	

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F 441	<p>Continued From page 55</p> <p>*C-diff risks. -Golden Living policy will be reviewed.</p> <p>*C-diff protocols. -Golden Living policy will be reviewed.</p> <p>*Equipment that cannot be left in the room must be wiped down with approved bleach wipe and left wet for 5 minutes before using for another resident.</p> <p>*Handwashing competency will be completed. Specific education will be provided to housekeeping regarding disinfectant protocols by the Director Clinical Education or Housekeeping Manager before the end of their next shift. DNS or designee will audit that all residents with C-diff or other need for precautions have the proper signage weekly times 4 weeks. DNS or designee will observe staff entering said resident's room for proper procedures at least one time a week times 4 weeks. DNS will report results to QAPI and monitor from there."</p> <p>Surveyor: 33488 1a. Observation and interview on 12/16/14 at 9:18 a.m. on the initial survey tour with resident 6 in his room revealed: *An isolation cart was placed inside his room beside his opened door. *He stated he had been at the facility "maybe two weeks." *He was unsure why the isolation cart was in his room. *There was no signage on the outside of the door or room that would notify staff or visitors to consult with the nurse prior to entering his room.</p> <p>Interview on 12/16/14 at 10:00 a.m. with licensed practical nurse (LPN) K regarding resident 6 revealed: *He was a new admission on 12/12/14.</p>	F 441			

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F 441	<p>Continued From page 56</p> <p>*He had been admitted with C-diff diagnosed while he had been in the hospital immediately prior to his admission. *She stated he was on contact precautions.</p> <p>Review of resident 6's medical record revealed he was: *Admitted on 12/12/14 with diagnoses of kidney disease requiring dialysis (mechanical filtering of a patient's blood when the kidneys were not working correctly), diabetes, high blood pressure, chronic pain, depression, C-diff infection, and a healing clavicle (collarbone) fracture. *On Flagyl (antibiotic) for his C-diff infection.</p> <p>Review of resident 6's bowel records revealed he had been experiencing diarrhea since his admission.</p> <p>Review of resident 6's current 12/12/14 temporary care plan revealed there was no mention of the resident having C-diff or what precautions were needed for staff and visitors.</p> <p>Interview on 12/16/14 at 11:05 a.m. with the laundry supervisor revealed: *Laundry from a resident on isolation would come to the laundry in a bag marked with a biohazard sticker. The biohazard sticker was approximately 2 inches by 2 inches *The sticker would be placed on the bag by nursing staff prior to it going to the laundry soiled utility room. *Those bags would be washed at the end of the day with bleach and hot water. *She had not been aware of resident 6's diagnosis of C-diff. *She was not told what type of infection residents who were on precautions had.</p>	F 441			

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F 441	<p>Continued From page 57</p> <p>*She stated she "just knew to wash those resident's items in the "isolation cycle" by the stickered bag that came down to laundry." *She would put on gloves and a gown prior to handling the isolation bags. *She had not received any training on C-diff precautions.</p> <p>Observation and interview on 12/16/14 with the bath aide/certified nursing assistant (CNA) C regarding disinfection of the whirlpool bath and shower revealed: *Residents with an infection or open wounds received a shower. *She had not yet bathed resident 6. *She would find out each day which residents needed a shower from the nurse. *She was not told by nursing what type of infection any particular resident had. *Her cleaning procedure for the shower chair and stall was to spray the shower and chair with A456 II and wait five to ten minutes, then rinse as instructed on the bottle. *She was unsure if the above product killed C-diff. *"That's what I was told to use."</p> <p>Review of the manufacturer's reference sheet for the above cleaner revealed it was not effective in killing C-diff bacteria.</p> <p>Surveyor: 35121 Preceptor: 33488 b. Observation on 12/16/14 at 12:44 p.m. of resident 6's room revealed a lunch tray was in his room on a table near the foot of the bed. On the plastic tray was regular silverware, a plate, a plate cover, a cloth napkin, and glassware.</p>	F 441			

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F 441	<p>Continued From page 58</p> <p>Observation on 12/16/14 at 12:55 p.m. with physical therapist (PT) U in resident 6's room revealed:</p> <ul style="list-style-type: none"> <li>-Resident had been sitting up on the side of the bed while he had an emesis episode (thrown up) in a garbage can.</li> <li>-PT U had been standing near his bed wearing gloves.</li> <li>-She had left the room with gloves on and asked for assistance at the nurse's station.</li> <li>-She and LPN K had entered his room and shut the door.</li> <li>-PT U had opened the door and carried the tray from the room with gloves on to the dining room.</li> <li>-She placed the tray on a table in the dining room.</li> <li>-She asked kitchen staff in the dishwashing area for toast for resident 6.</li> <li>-Resident 6's menu sheet was on the tray.</li> </ul> <p>Observation on 12/16/14 at 1:00 p.m. and at 1:08 p.m. revealed the tray with resident 6's menu sheet on it had remained on the table in the dining room.</p> <p>Observation on 12/16/14 at 6:13 p.m. of an unidentified CNA entering resident 6's room revealed she:</p> <ul style="list-style-type: none"> <li>*Had not put on gloves or a gown.</li> <li>*Had not washed her hands when she had left his room.</li> </ul> <p>Surveyor: 33488</p> <p>Observation and interview on 12/16/14 of occupational therapist (OT) E and resident 6 in his room revealed:</p> <ul style="list-style-type: none"> <li>*She was not wearing gloves or a gown while in his room.</li> <li>*She left the room without washing or sanitizing her hands carrying her computer tablet.</li> </ul>	F 441			

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F 441	<p>Continued From page 59</p> <p>*When asked why she had not washed her hands prior to leaving the room she replied she did not want to "catch germs that may be in the [resident's] sink."</p> <p>*She stated she was going to go back to the OT room located at the other end of the facility to wash her hands.</p> <p>*She was aware he had "an infection".</p> <p>*She was "told she did not need to wear gloves or a gown if she was not providing personal care."</p> <p>c. Interview on 12/16/14 from 5:30 p.m. through 6:00 p.m. with registered nurse (RN) F regarding resident 6 revealed:</p> <p>*She usually wore gloves when entering his room.</p> <p>*She was aware he had C-diff but could not tell me what precautions that required.</p> <p>*She was responsible to provide his breathing treatments and blood glucose monitoring.</p> <p>*He had his blood sugar tested previously that day.</p> <p>*The resident was scheduled to have his blood sugar checked four times per day according to the treatment administration record.</p> <p>*She was asked what she used to test his blood sugar with and she pointed to the glucometer (blood sugar monitoring machine) on her cart.</p> <p>*She stated he did not have a dedicated glucometer to leave in his room.</p> <p>*She cleaned the glucometer with an alcohol wipe.</p> <p>*When asked if she knew if alcohol killed C-diff she replied "no."</p> <p>*She stated she had eight other residents she had used that same glucometer on to check blood sugars that day.</p> <p>*When asked about his nebulizer treatments (breathing treatment) and the equipment used she stated she thought he had a nebulizer</p>	F 441			

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F 441	<p>Continued From page 60</p> <p>dedicated to him located in his room.</p> <p>*She then went to the resident's room to check for the nebulizer.</p> <p>*She had not put on a gown or gloves prior to entering resident 6's room.</p> <p>*She opened his dresser drawers with her bare hands.</p> <p>*She then bumped the resident's bedside table with her back side, turned around and faced the table and moved it out of the way with her bare hands.</p> <p>*After she had been unable to find the nebulizer she proceeded to walk to the door.</p> <p>*She walked past the sink and had almost left the room.</p> <p>*She had stopped, turned around, went back into the room, and washed her hands in the sink with soap and water.</p> <p>*When asked why she had not gowned and gloved prior to entering the room she stated "I didn't. That was wrong."</p> <p>d. Observation and interview on 12/16/14 at 6:10 p.m. with CNA G regarding resident 6's cares revealed:</p> <p>*She was aware he had C-diff but was unsure what exact precautions were needed for his care.</p> <p>*She stated he had been incontinent of stool since his admission on 12/12/14.</p> <p>*He required the use of a stand aide (device to transfer a resident from one surface to another.)</p> <p>*She would use the stand-aide to toilet the resident.</p> <p>*The stand aide was brought into and out of the resident's room each time it had been needed.</p> <p>*When asked what she did to clean the stand aide she replied "we use the purple wipes, the Sani-wipes I think is what they are called."</p> <p>*She stated they were stored in the clean utility</p>	F 441			

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F 441	<p>Continued From page 61</p> <p>but when she attempted to show this surveyor none could be found.</p> <p>*She had stated there were two stand aides located in the facility and were used by all residents who required that type of lift.</p> <p>e. Observation on 12/16/14 at 6:33 p.m. of dietary aide I bringing resident 6 his supper tray revealed:</p> <p>*He knocked on the resident's door with tray in hand.</p> <p>*He had not put on a gown or gloves prior to entering.</p> <p>*He set the tray on the bedside table.</p> <p>*He pushed the table with his bare hands closer to the resident.</p> <p>*He then proceeded to leave the room without washing his hands.</p> <p>*He walked to the hand sanitizer unit in the hallway and put sanitizer on his hands and proceeded back to the kitchen.</p> <p>*He was unaware of what infection the resident had.</p> <p>*He was unaware he needed to follow contact precautions and appropriate hand hygiene when entering and leaving the room.</p> <p>*He thought hand sanitizer was effective against all germs.</p> <p>Surveyor: 30170</p> <p>f. Observation on 12/17/14 at 10:00 a.m. outside of resident 6's room revealed:</p> <p>*PT U took a wheelchair that had been placed in resident 6's room and was going to use the wheelchair for another resident across the hall.</p> <p>*She was immediately stopped by the DON and instructed she could not store the wheelchair in resident 6's room.</p>	F 441			

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F 441	<p>Continued From page 62</p> <p>Interview immediately following the observation with PT U revealed she was just going to get the wheelchair out of the hallway. She did not realize she could not place the wheelchair in resident 6's room.</p> <p>Surveyor: 33488 g. Interview on 12/17/14 at 12:55 p.m. with RN T from the outpatient dialysis center regarding resident 6's dialysis revealed: *His first day of dialysis at the center had been Monday, 12/15/14. *The dialysis center had not been made aware of his active C-diff infection from the provider prior to him receiving dialysis treatment. *They were unaware the resident was incontinent. *They were not equipped with undergarments if the resident had become incontinent while he was in their facility. *To her knowledge he had not been incontinent while he was at the dialysis center. *"We will start contact precautions right away."</p> <p>Interview on 12/18/14 at 1:30 p.m. with the DON and administrator revealed: *"He had received dialysis before he even got to our facility so they [the dialysis center] knew." *The resident had recieved dialysis at the hospital prior to his admission, not the outpatient dialysis center as she had thought. *The DON stated "We send them a report on medications. His Flagyl is on there and he's on that for C-diff." *She was unaware he was receiving dialysis since his admission to the facility from [name] outpatient dialysis center and not from the hospital that he had been admitted from. *She agreed that the dialysis center should have been notified in advance of treatment the resident</p>	F 441			

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F 441	<p>Continued From page 63</p> <p>had C-diff.</p> <p>*She agreed there needed to be better communication with the outside dialysis center.</p> <p>*She agreed staff needed education regarding contact precautions and appropriate used of personal protective equipment.</p> <p>She stated staff would receive infection control training that day and as they came into work.</p> <p>*She agreed it was her expectation staff follow their (the facilities) policy regarding appropriate precautions used for infection control.</p> <p>*She agreed his care plan was not specific to the resident's needs and level of care and had not addressed his C-Diff infection.</p> <p>Surveyor 35120 Preceptor 30170</p> <p>h. Interview on 12/16/14 at 11:20 a.m. with certified nursing assistant (CNA) N regarding resident 8 revealed:</p> <p>*The resident was still symptomatic for C-diff, and isolation precautions were still in effect.</p> <p>*The provider had not used signs to alert staff, visitors, and family members of the need to use isolation precautions.</p> <p>Interview on 12/16/14 at 11:21 a.m. with licensed practical nurse (LPN) A regarding resident 8 revealed:</p> <p>*She believed the resident still had C-diff.</p> <p>*She thought the family did not want signs on the resident's door but was unsure.</p> <p>Interview on 12/16/14 at 11:23 a.m. with contracted housekeeper Q regarding C-diff infection control procedures revealed:</p> <p>*She had only been employed with the contracted housekeeping services for two weeks.</p> <p>*Her regularly schedule shift hours were 7:00</p>	F 441			

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F 441	<p>Continued From page 64</p> <p>a.m. to 2:30 p.m. but had to work until 4:00 p.m. on some days to complete all of her work. She was the only housekeeper on duty.</p> <p>*There were no special cleaning substances that were used in rooms of residents with infections. She only changed the mop head with each resident room cleaning.</p> <p>*She was unaware of any current infections within the facility, and therefore the only personal protective equipment (PPE) that she wore was gloves.</p> <p>Interview on 12/16/14 at 12:02 p.m. and again at 4:00 p.m. with district manager of the contracted services H revealed:</p> <p>*That Healthcare services contracted with the facility on 11/16/14 for housekeeping and laundry services.</p> <p>*They were short staffed for both laundry and housekeepers, and currently had ads posted for two full time positions.</p> <p>*The provider was not posting signs regarding infections, and the contracted staff were not being informed by nursing staff if any of the residents had infections.</p> <p>*She confirmed housekeeper Q was still on orientation and had not completed the appropriate paperwork, therefore should not have been working independently.</p> <p>*Housekeeper Q had not had any training of C-diff. and how to care for those resident's rooms.</p> <p>i. Interview on 12/16/14 at 11:30 a.m. with the director of nursing (DON) regarding resident 8 revealed:</p> <p>*She was unsure if the resident had C-diff. She would have to check the resident's chart to confirm the infection.</p>	F 441		

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F 441	<p>Continued From page 65</p> <p>*During the interview she went to the resident's chart and confirmed the resident was not symptomatic (did not currently have diarrhea).</p> <p>*No signs were posted on the resident's door to notify staff and visitors of the infection due to confidentiality.</p> <p>*Staff would be informed about any resident's infections from stand-up (report from staff to the oncoming shift), but visitors would not have known about any precautions needed prior to entering the room.</p> <p>*The resident returned from the hospital on 12/9/14 with C-diff and finished her antibiotics on 12/13/14.</p> <p>Interview on 12/16/14 at 12:11 p.m. with the DON regarding resident 8 revealed:</p> <p>*When the resident was readmitted from the hospital she was put into her same room with a roommate, resident 2, who had an open area to her coccyx.</p> <p>*All the isolation supplies were kept in the resident's room.</p> <p>Interview on 12/16/14 at 2:30 p.m. with infection control/staff training coordinator P regarding infection prevention and control practices revealed:</p> <p>*She had been the infection control nurse for ten years.</p> <p>*She had been to a few infection control conferences.</p> <p>*She spent little time on infection control due to other job duties.</p> <p>*When a resident had an infection and was placed on contact isolation precautions the staff would:</p> <p>-Place the soiled linen in a water soluble clear plastic bag.</p>	F 441			

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F 441	<p>Continued From page 66</p> <p>-Then place that clear plastic bag into another trash bag.</p> <p>-Mark that plastic bag with a small hazardous sticker to alert staff of the infected linen. When asked what would happen if the hazardous sticker would fall off during transportation of the infected linen to the laundry room she had no answer.</p> <p>*Infection control training for all staff was done upon hire and annually.</p> <p>*Residents on isolation precautions had regular plates, glasses, and utensils brought into their rooms for meals.</p> <p>*The provider used infection control signs to inform staff and visitors but stopped placing signs on the doors due to confidentiality.</p> <p>*Garbage was placed into a regular garbage bag and a biohazard sticker was placed on the bag.</p> <p>Interview on 12/18/14 at 1:10 p.m. with RN L regarding resident 8 revealed:</p> <p>*The resident had diarrhea at that time while the RN was providing Foley catheter care.</p> <p>*The RN stated the resident had diarrhea due to the fact she had C-diff.</p> <p>2. Interview and record review on 12/17/14 at 9:00 a.m. with infection control/staff training coordinator P regarding infection control practices and the training of staff revealed:</p> <p>*The contracted housekeeping and laundry services employees had never attended any of her yearly mandatory inservices regarding infection control practices.</p> <p>*Infection control issues were usually handled and discussed at the stand-up meetings daily or with shift changes.</p> <p>*The provider had a low census of residents, so mandatory monthly meetings were not</p>	F 441			

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F 441	<p>Continued From page 67 conducted.</p> <p>*The provider had several residents in the past year with C-Diff, but there had been no formal training given to the staff.</p> <p>*There was no systemic process in place to keep track of annual training provided to staff. Some of the training was provided on the computer, and some of the training had been provided on paper. There was no system to track the annual training of employees.</p> <p>*She did not have many hours to dedicate to the infection control program.</p> <p>Review of the provider's October 2013 Clostridium Difficile policy revealed:</p> <p>*Primary reservoirs (surfaces) for C-diff are infected people and surfaces.</p> <p>*(C-diff) spores can live for several months and are resistant to common cleansers.</p> <p>*Frequent hand washing with soap and water by staff and residents.</p> <p>*Wearing gloves when handling items with potential contamination,</p> <p>*Disinfecting items in the room that may be contaminated with an EPA approved cleaner such as bleach is required.</p> <p>Surveyor: 30170 Review of the October 2008, Vol. 29, Supplement 1, Center for Disease Control Clostridium Difficile infection recommendations, revealed:</p> <p>*Initiate Contact Precautions.</p> <p>*Place the patient in a single-patient room.</p> <p>*Ensure gloves and gowns were easily accessible.</p> <p>*Remind staff to wash hands with soap and water following patient(resident) contact.</p> <p>*Alert housekeeping the patient was on contact precautions.</p>	F 441			

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F 441	<p>Continued From page 68</p> <p>*Clean the room with a bleach-based cleaning agent.</p> <p>B. Based on observation and interview, the provider failed to perform appropriate hand hygiene during Foley (tube inserted into the bladder to drain urine) catheter care observed for two of two sampled residents (7 and 8). Findings include:</p> <p>1. Observation on 12/18/14 at 1:10 p.m. with RN L revealed: *She gathered her supplies and put them on a towel on resident 8's bed then put gloves on her hands. *While she was performing the care she needed additional supplies. *She got the supplies out of the resident's drawer that contained linen and clean supplies with the same gloves on her hands. *Then she continued the Foley catheter care with those same gloves on her hands. *She had not changed her gloves after touching the drawer to the cabinet.</p> <p>Interview with RN L on 12/18/14 at 1:30 p.m. revealed she agreed she should have removed her gloves before getting more supplies. She should have washed her hands and put on new gloves before resuming the Foley catheter care.</p> <p>Interview with the DON on 12/18/14 at 5:00 p.m. revealed they did not have a Foley catheter policy.</p> <p>Surveyor: 34030</p> <p>2. Observation and interview on 12/18/14 at 9:15 a.m. with CNA M during urinary catheter care for resident 7 revealed:</p>	F 441			

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F 441	<p>Continued From page 69</p> <ul style="list-style-type: none"> <li>*She put on gloves, emptied the urine from the resident's urine catheter bag into a measuring container, and then emptied the urine into the bathroom toilet.</li> <li>*She took the container out to the resident's sink which contained personal care items and was shared with a roommate.</li> <li>*She then rinsed and poured the contents of that urinal into the sink.</li> <li>*She placed a clean washcloth into the sink then removed and threw away her gloves.</li> <li>*Without washing her hands she picked up scissors to hand to the resident to use to change her colostomy bag (a bag on the abdomen and over an opening from the bowel that collects stool).</li> <li>*She put on new gloves without washing or sanitizing her hands.</li> <li>*She took the washcloth from the sink and washed the resident's private area around the catheter, then removed her gloves and washed her hands.</li> <li>* CNA M agreed she should have washed her hands after she had removed her gloves the first time and before picking up the scissors and providing catheter care.</li> </ul> <p>Interview on 12/18/14 at 11:45 a.m. with RN P regarding CNA M revealed she would have expected CNA M to use the correct handwashing procedure when giving catheter care. She would have expected the urinal to not be rinsed in the resident's sink.</p> <p>Interview on 12/18/14 at 3:50 p.m. with the DON revealed:</p> <ul style="list-style-type: none"> <li>*She agreed CNA M had not followed adequate infection control practice.</li> <li>*No facility procedure or policy on urine catheter</li> </ul>	F 441		

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F 441	<p>Continued From page 70 care existed.</p> <p>Review of Patricia A. Potter and Anne Perry's Fundamentals of Nursing, 8 th edition, St. Louis Mo., 2013, p. 414, revealed "Perform hand hygiene after contact with blood, body fluids, mucous membranes, nonintact skin, secretions, excretions, or wound dressings; after contact with inanimate surfaces or articles in a patient room; and immediately after gloves are removed."</p> <p>Surveyor: 30170 C. Based on observation, interview, and podiatry contract review, the provider failed to ensure contracted podiatry (foot care) services staff were following infection control practices according the the provider's policies and procedures. Findings include:</p> <p>1. Observation and interview on 12/16/14 at 9:30 a.m. in the 300 wing revealed a person with blue gloves on each hand walking up and down the hall and pushing residents in their wheelchairs. Interview during the observation revealed she was a certified medical assistant that worked for a podiatrist (foot doctor) that had been visiting the provider that day and was delivering podiatry services to multiple residents.</p> <p>Surveyor: 32335 Interview on 12/16/14 at 10:00 a.m. with certified medical assistant V revealed she would change her gloves after assisting 2-3 residents. She would not wash her hands unless they were visibly dirty. She would touch the wheelchairs and would take the residents shoes and socks off. She would then assist them with putting them back on after the visit with the podiatrist. She had</p>	F 441		

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F 441	Continued From page 71 not received any education from the facility on what their expectation was for washing her hands or changing gloves.  Surveyor: 33488 Observation and interview on 12/16/14 at 11:25 a.m. with contracted podiatrist H revealed: *He was wearing gloves when he was not providing patient care. *When asked what his expectations were with his contracted staff who accompanied him regarding glove use he stated, "Ideally we try to change gloves but don't always. What would you recommend we do?" *He also stated he had not routinely changed gloves or performed hand hygiene in-between resident care.  Review of the podiatrist's schedule for 12/16/14 revealed the podiatrist was scheduled to provide foot and nail care for thirty-three of the provider's fifty-two residents.  Review of the provider's January 2011 Healthcare Services Agreement Podiatry Contract revealed: *The contractor and the contractor's staff shall provide services: -With accepted professional standards of practice. -And adhere to the provider's policies and procedures when providing resident care.	F 441			
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION  The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	F 456	F 456 Essential Equipment, Safe Operating Condition  The ice machine in the clean utility room across from the nurses' station has been cleaned.  Residents residing in the facility have the potential to be affected.		

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435049</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - SALEM</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 COLONIAL DRIVE SALEM, SD 57058</b>		
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F 456	<p>Continued From page 72</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on observation and interview, the provider failed to keep one of one ice machine clean in one of one clean utility room across from the nurses station. Findings include:</p> <p>1. Observation on 12/17/14 at 3:45 p.m. in the clean utility room across from the nurses station revealed: *There was a dried whitish substance on the whole ice machine. *The drainage area for the excess water was coated with the whitish substance. *The entire ice machine was unclean and unkept.</p> <p>Interview on 12/17/14 at 4:00 p.m. with the maintenance supervisor revealed: *He had been newly employed with the provider. *Ice from the ice machine was used for resident and staff use. *The city had hard water, and it was extremely difficult to keep the hard water build-up off the ice machine. *He agreed the ice machine needed to have some extensive cleaning.</p>	F 456	<p>The ice machines will be placed on a routine cleaning schedule</p> <p>The maintenance staff will be educated of the routine cleaning schedule.</p> <p>Executive Director or designee will audit the ice machines after routine cleanings have been completed x 3 months to ensure cleaning has been completed appropriately. Executive Director will report results of the audits and they will be reviewed by the QAPI committee for further recommendations.</p>	1/20/15
F 466 SS=D	<p>483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY</p> <p>The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.</p>	F 466	<p>F 466 Procedures to ensure water availability</p> <p>Executive Director contacted organizations listed in the</p>	

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F 466	<p>Continued From page 73</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335</p> <p>Based on policy review and interview, the provider failed to ensure the water outage policy reflected who would provide the needed water or how they would store or distribute the potable (suitable for drinking) and non-potable water. Findings include:</p> <p>1. Review of the undated Water Outage policy from Emergency Action Plan-Utility Outage and Shut-Off revealed: *There was no mention of how they would store the potable and non-potable water. *There was no mention of how they would distribute the water. *It had been unclear who would deliver what percentage of water needed.</p> <p>Interview on 12/17/14 at 9:30 a.m. with the director of nursing revealed they had not contacted any of the provider's on the list for at least two years which had been the last time they needed water. They had no agreement with any provider on the list to provide them with potable or non-potable water.</p>	F 466	<p>facilities Emergency manual to sign a formal contract.</p> <p>QI is complete as contract is obtained and current.</p>	1/20/15

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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - SALEM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 COLONIAL DRIVE SALEM, SD 57058</b>
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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 12/17/14. Golden LivingCenter - Salem was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies upon correction of deficiency identified at K076 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	<i>Addendums noted with an asterisk per pending telephone to facility administrator. JB/SDDH/MT</i>	
K 076 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4  This STANDARD is not met as evidenced by: Surveyor: 14180 The provider must comply with the National Fire Protection Association (NFPA 99) Health Care Facilities section 4-3.5.2.1 (27) cylinder and	K 076	<b>K076 Life Safety Code Standard</b>  <b>Cylinders were secured.</b>  <b>Signage was posted to remind staff that all cylinders must be secured.</b>  <b>Maintenance Supervisor or designee will audit the O2 storage to ensure that all appropriately stored weekly x4 weeks and then monthly x 3 months to ensure proper storage continues. Maintenance Supervisor will report results of the audits and they will be reviewed by the QAPI committee</b>  <i>x [redacted] monthly. JB/SDDH/MT</i>	<i>1/20/15</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Deonna J Smith</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>1/15/15</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JAN 20 2015

If continuation sheet Page 1 of 2

SD DOH L&C

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - SALEM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 COLONIAL DRIVE SALEM, SD 57058</b>		
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K 076	Continued From page 1 container storage requirements (see attachment).  Based on observation and interview, the provider failed to secure 2 of 34 oxygen cylinders in the oxygen storage room, to prevent tipping. Findings include:  1. Observation at 10:30 a.m. on 12/17/14 revealed two oxygen cylinders in the oxygen storage room were not secured. Interview with the plant operations manager at the time of observation confirmed that finding. This deficiency would affect one of two resident smoke compartments.	K 076			

South Dakota Department of Health

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S 000	Initial Comments  Surveyor: 32335 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 12/16/14 through 12/18/14. Golden LivingCenter - Salem was found not in compliance with the following requirement(s): S301.	S 000	<p><i>Addendums noted with an asterisk per 1/14/15 telephone and email to facility administrator. KESDDOH/MF</i></p> <p>05301 Required Dietary In Service Training</p>	
S 301	<p>44:04:07:16 Required dietary in-service training</p> <p>The dietary manager or the dietitian in ...nursing facilities...shall provide ongoing in-service training for all dietary and food-handling employees...Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32335 Based on interview and policy review, the provider failed to ensure six of nine necessary dietary in-services were conducted in the past year. Findings include:</p> <p>1. Interview on 12/17/14 at 11:20 a.m. with the dietary manager revealed: *She had only provided three of the nine required dietary in-services. *She had found articles on infection control, nutrition, and food temperatures that she had put</p>	S 301	<p>Food Borne Illness was previously completed in October 2014. Nutrition &amp; Hydration was completed in December 2014 and Time &amp; Temp Controls completed July 2014.</p> <p><i>*remaining w KESDDOH/MF</i></p> <p>The [redacted] of the required topics were presented to dietary staff 1/14/15.</p> <p>For future compliance, the 2015 in-service schedule was drafted and is planned for review and update each December.</p> <p>Dietician Specialist or designee will audit during her monthly visits that education is completed according to schedule monthly x 3 months. Dietary Manager will report results of the audits and they will be reviewed by the QAPI committee for further</p>	1/20/15

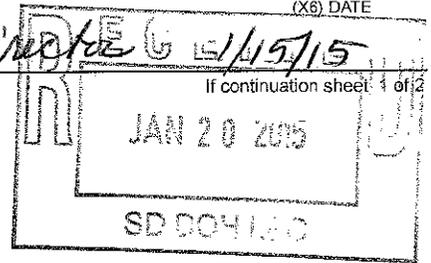
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Ronnica Smith*

TITLE

*Executive Director* 1/15/15

(X6) DATE



South Dakota Department of Health

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S 301	<p>Continued From page 1</p> <p>out for staff to read. *She had not found any sign-in sheets to go along with those trainings. *She could not locate any information on the last time the other six in-services including food safety, handwashing, food handling and preparation techniques, serving and distribution prodedures, leftover food handling policies, and sanitation requirements had been completed.</p> <p>Review of the provider's 2011 Golden Living In-Service Education policy revealed: *An ongoing education program should have been planned and implemented. *"The director of dining was responsible for training and educating dining service employees in job functions and federal and state requirements." *The director of dining should have planned "in-services (including mandatory in-services) monthly for a 12-month period."</p>	S 301		