

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

PRINTED: 12/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SCOTLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 130 6TH STREET SCOTLAND, SD 57059
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 274 SS=D	<p>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility did not complete a comprehensive assessment of a resident within 14 days after the facility determined, or should have determined, that there had been a significant change in the resident's physical or mental condition for 1 of 10 sampled residents (resident #4). Specifically for resident #4 who was identified as having a decline in condition which required interdisciplinary review or revision of the care plan. A significant change as defined in the Long Term Care Resident Assessment Instrument (RAI) User's Manual, prepared by Health Care Financing Administration (HCFA) in October, 1995 is "a major change in the resident's status that: 1. Is not self-limiting; 2. Impacts on more than one area of the resident's health status; and 3. requires interdisciplinary review or revision of</p>	F 274	<p>F 274 Comprehensive Assess After a significant change. A significant change MDS with an ARD of 12/13/14 was initiated on Resident #4. The interdisciplinary team will revise Resident #4 care plan and ensure it is comprehensive using the Resident Assessment Instrument (RAI) process. All residents must be monitored during the course of their stay for significant changes in conditions. An addendum has been added to the facilities procedure for Comprehensive Care Plan and Care Conferences II.C.3.a. The addendum adds a Quality of Life review requirement for all residents. This review will be a comprehensive evaluation of the residents status, including activities of daily living (ADL's), any short term issues, skin condition, behavioral or mood symptoms, change in cognition, restraint or positioning devices, pain, restorative programs, falls, medications, nutrition risk, hydration risk, continence, sleep patterns or change in condition. Data will be collected in these areas via the use of Nursing Documentation User Defined Assessments (UDA's) and by interview of certified nursing assistants (C.N.A's). Each resident will have a Quality of Life Review quarterly, on a schedule to fall midway between their MDS quarterly cycles. In addition, any resident with an acute illness will be identified and monitored by the Quality of Life committee on a weekly basis while ill to ensure a significant change in condition, if it occurs, is identified and addressed. The quality of life committee will include the members of the interdisciplinary team; will meet weekly, and a Care Plan Review progress note (PN) will be documented in the resident record to reflect this comprehensive review and monitoring for significant change of status.</p> <p>On January 6, 2015 a Nurse Consultant and the Director of Nursing (DNS) will provide education to all staff related to identification of significant changes in resident status, and in the development of the Quality of Life process and the addendum to the nursing procedure IIC.3.a. The implementation of the Quality of Life review will follow this in-service.</p> <p>To ensure compliance with the identification of significant changes as required by F274, and to ensure compliance with the addendum to II.C.3.a., the Quality Assurance Performance Improvement (QAPI) nurse and/or the DNS will conduct audits of one Quality of Life Review weekly x4 and then monthly x3. Findings of these audits will be shared at monthly QAPI meetings by the DNS and discussed. In addition, the QAPI nurse and/or DNS will monitor a completed quarterly MDS and compare it with that residents last quarterly MDS to ensure a significant change in condition was not missed, and to ensure that the resident care plan matches the MDS ADL areas. This audit will be done on one completed quarterly MDS weekly x4, then monthly x3, with findings being reported at the monthly QAPI meeting for discussion and review. After review of the last of these scheduled audits, the QAPI committee will determine the need for any additional interventions or focused monitoring. Date certain January 20, 2015.</p>	<p>1/20/2015</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Quinn Kamey</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12/26/14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 274	<p>Continued From page 1</p> <p>the care plan." "A significant change assessment is appropriate if there is a consistent pattern of changes, with either two or more areas of decline, or two or more areas of improvement."</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Resident #4's medical record review revealed the resident was admitted to the facility on 9/29/11 with diagnoses which included: osteoarthritis, hypertension, CHF (congestive heart failure), esophageal reflux, arthritis, depression, gout, constipation and pain. The resident was also identified as having an open area on her right hip related to prior surgical skin graft. 2. Record review of resident #4's 7/29/14 annual Minimum Data Set (MDS) assessment and of the 10/21/14, quarterly MDS assessment showed that the resident experienced the following changes from 7/29/14 to the 10/21/14 quarterly assessment: <ul style="list-style-type: none"> 7/29/14 - Bed mobility was coded as requiring supervision with set-up assist (1-2). 10/21/14 - Bed mobility was coded as extensive assistance by one person physical assist (3-2). 7/29/14 - Transfer was coded as requiring supervision with set-up assist (1-2). 10/21/14 - Transfer was coded as extensive assistance by one person physical assist (3-2). 7/29/14 - Locomotion on unit was coded as ADL self-performance with no assist (0-0). 10/21/14 - Locomotion on unit was coded as extensive assistance by one person physical assist (3-2). 	F 274		

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F 274	<p>Continued From page 2</p> <p>7/29/14 - Locomotion off unit was coded as requiring supervision with set-up assist (1-2). 10/21/14 - Locomotion off unit was coded as extensive assistance by one person physical assist (3-2).</p> <p>7/29/14 - Personal hygiene was coded as ADL self-performance with no assist (0-0). 10/21/14 - Personal hygiene was coded as extensive assistance by one person physical assist (3-2).</p> <p>7/29/14 - Bathing was coded as limited assist with one person physical assist (2-2). 10/21/14 - Bathing was coded as extensive assistance by one person physical assist (3-2).</p> <p>The MDS on 7/29/14 indicated the resident was also had a depression score of 8 (5-9 mild depression). On 10/21/14 the resident's depression score was 12 (10-14 moderate) depression.</p> <p>3. Review of the resident's plan of care showed that not all the areas of decline were addressed in the ADL (activities of daily living) to meet the resident's needs.</p> <p>4. On 12/10/14 at 4:00 PM, during an interview with the staff member who completes the MDS assessments, she verified through record review that the resident had experienced changes on the quarterly MDS which on paper indicated a decline and need for significant change. She also indicated that the resident had some days better than others. The resident wanted to be as independent as possible but was requiring more care which needed to be addressed in the</p>	F 274		

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<p>F 274</p> <p>F 309 SS=E</p>	<p>Continued From page 3 resident's plan of care.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to provide necessary care and services for 3 of 10 sampled residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. This is related to: lack of pain management for residents (#6, #7 and #9). These failures resulted in a lack of timely assessments and interventions appropriate to treat the residents with conditions and potential for residents to have unrelieved pain. The findings included:</p> <p>1. Resident #6's medical record review revealed that the resident was admitted to the facility on 7/13/11 and had a readmission from the hospital on 10/17/13. The resident's diagnoses included: Alzheimer's disease, hypertension, chronic ischemic heart disease, asthma, diabetes, weight loss, constipation and edema.</p> <p>a. Review of resident #6's MDS (minimum data set) assessment on 11/11/14 identified the</p>	<p>F 274</p> <p>F 309</p>	<p>F 309 Care and Services</p> <p>Resident #6 had a PAINAD completed on 12/10/14. Acetaminophen 325mg 2 tabs PRN was ordered 12/10/14 as it indicated moderate pain. The care plan was updated that day to include the potential for pain as indicated by behaviors, and as a result of an open wound on the coccyx on 12/10/14. The interdisciplinary team has been monitoring resident #6 behaviors and response to interventions. Resident #7 and #9 had a PAINAD on 12/23/14 and Pain Assessment User Defined Assessment (UDA) done on 12/24/15.</p> <p>All residents with a severe cognitive impairment have the potential for unidentified pain if not assessed. Two addendums have been added to the facilities policy procedure on Pain Data Collection and Assessment II.P.1a. For residents who are unable to answer simple questions appropriately or who do not respond when spoken to, or whose score is 0-7 on the Brief Interview for Mental Status (BIMS) (which indicates severe cognitive impairment with or without a diagnosis of dementia), a PAINAD UDA must be done in place of, or in addition to, a Pain Data Collection UDA. In addition, with any new or worsening behavior symptoms exhibited by a cognitively impaired resident, a PAINAD and Pain Assessment UDA will be done prior to the start of or dose increase on a psychotropic medication.</p> <p>On January 6, 2014 an in-service will be done by a nurse consultant and the registered pharmacist for all staff on the topic of recognizing pain in cognitively impaired residents. The Good Samaritan Society Policy and Procedure for Pain Data Collection and Assessment will be thoroughly reviewed, and Point Click Care's (PCC) Pain as a Vital Sign will be shown and discussed. Pain verses behaviors will be reviewed and examples given to assist staff in identifying the difference. The implementation of the updated procedure II.P.1a will follow this in-service.</p> <p>To ensure ongoing compliance, the Director of Nursing Services (DNS) or designee will audit residents with cognitive impairments for signs and symptoms for pain. The audit will evaluate if the PAINAD was completed, any follow up done, use of analgesic medications, use of psychoactive medications, use of non-pharmacological interventions, and how the resident responded. These audits will be done on residents with a BIMS score of 3, or any cognitively impaired resident exhibiting new or worsening behavior symptoms. The audits will be done weekly x4 weeks, then monthly x3. The DNS will report findings to the Quality Assurance Performance Improvement committee at their monthly meetings. Following the last of the scheduled audits and QAPI reporting, the QAPI team will determine the need for further interventions or additional monitoring of the facilities pain management policy and procedures.</p> <p>Date certain 1/20/15</p> <p style="text-align: right;"><i>92</i> <i>1/20/2015</i></p>
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F 309	<p>Continued From page 4 resident as the following:</p> <ul style="list-style-type: none"> -BIMS (BRIEF INTERVIEW FOR MENTAL STATUS) score of 99 as unable to interview, [Use Code 99 if: The individual chooses not to participate, or 4 or more items were coded 0 because the individual chose not to answer or gave a nonsensical response. [Note: Nonsensical response means any response that is unrelated, incomprehensible, or incoherent; it is not informative with respect to the item being rated.] -Behaviors marked as "yes" (noted behaviors were swearing at staff and yelling "Help Me"), -Extensive assistance from staff with all ADL's (activities of daily living), -Frequently incontinent of bowel and bladder, -Pain was marked as should be assessed with interview. <p>b. Review of resident #6's "Progress Notes" identified the following:</p> <ul style="list-style-type: none"> 10/28/14 treatment for cough, 11/3/14 Family notification that they were informed of dx (diagnosis) of URI (upper respiratory infection) and tx (treatment) which they agreed. This included antibiotics for 10 days. 11/17/13 high nutritional risk with history of weight loss identified. Staff provides extensive to total assist with all cares. 11/18/14 Care plan review noted, "Resident did not complete interview d/t (due to) resident unwilling to answer questions which is common 	F 309		

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F 309	<p>Continued From page 5</p> <p>for this resident. Resident has Alzheimer's Disease with altered cognitive function. Resident does have some behaviors noted most commonly with cares of grabbing, hitting and swearing at staff..."</p> <p>11/25/18 "Provider aware of open area to coccyx. Orders noted for Kendall soothing ointment with zinc TID (three times per day)."</p> <p>c. On 12/10/14 the resident was observed seated in a wheelchair by the nurses station. The resident was noted to repeatedly attempt to lean forward and reposition her bottom in the wheelchair. At 11:45 AM Nurse H went to check on the resident. The resident did open her eyes but did not verbally respond to the Nurse. The nurse then reported that the resident did pull back as having discomfort when ointment applied to her open area on the coccyx. Staff also reported the resident resisted staff when provided cares which could be potential for pain.</p> <p>d. Review of resident #6's care plan with revisions data of 11/18/14 did not address the resident's potential for pain. Additionally the care plan was not updated after the resident developed an open area on her coccyx on 11/25/14, which has the potential for causing pain.</p> <p>e. On 12/10/14 at 4:00 PM, during an interview with the staff member who completes the MDS assessments, she was asked how pain assessments were completed for non cognitive residents. She reported that a PAINAD (pain assessment in advanced dementia) would be completed. She was then asked if a PAINAD had been completed</p>	F 309		

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F 309	<p>Continued From page 6 for resident #6, which she replied, "no".</p> <p>Further review by facility staff showed that there were no current residents with documentation in "PointClick Care" of having the PAINAD assessment completed. The only resident listed as having had the pain assessment for advanced dementia or being cognitively impaired was done on 9/23/14 for a resident no longer in the facility.</p> <p>The MDS Coordinator also provided the list of 15 residents who were identified on the "Resident Census and Conditions of Residents" as having dementia. She confirmed that the PAINAD assessment had not completed on any of those 15 residents.</p> <p>2. Review of the facility's policy for "PAIN DATA COLLECTION AND ASSESSMENT" included:</p> <p>"PURPOSE To promote well-being by ensuring that residents are as comfortable as possible, To consistently collect information for data collection of pain in a systematic process, To determine what pain relief interventions that are specific to the resident that can be utilized and established to aid in maintaining a comfortable level of function and quality of life.</p> <p>Note: A pain management plan can include, but not be limited to, a medical regime. The analysis should help determine what other methods or alternatives of pain control/relief may be implemented before contacting a physician. The care team and nurses must continually monitor and evaluate the pain management plan.</p> <p>PROCEDURE</p>	F 309		

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F 309	<p>Continued From page 7</p> <p>1) Complete the Pain Data Collection UDA, which will be triggered from the Nursing Admit ReAdmit Data Collection UDA and also can be triggered manually. The Pain Assessment UDA will be triggered from the Pain Data Collection. Data collection using the Pain Data Collection or the PAINAD should be completed prior to the registered nurse's (RN) completion of the Pain Assessment.</p> <p>2) Determine and use the pain scale that works best for the resident's needs to identify pain and document on the Pain Data Collection. If the condition of the resident changes so that the preferred scale is different, the care plan should be updated.</p> <p>3) Following the data collection done by any licensed nurse the RN will complete the Pain Assessment. Using the information collected along with the input from the resident, other representatives if desired by the resident and the interdisciplinary team, a pain management plan specific to the resident will be developed. The physician should be aware of and participate in the plan as needed. This will include attempting specific non-pharmacological interventions as well as medications as appropriate.</p> <p>4) Develop care [plan including pain, goal and interventions...."</p> <p>The facility failed to follow this policy to ensure residents with dementia or altered cognitive function were properly assessed for pain and provided pain management.</p> <p>3. Review of two other sampled residents #7 and</p>	F 309		

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F 309	<p>Continued From page 8</p> <p>#9 were identified as having cognitive impairment and did not have adequate pain assessments. The examples included:</p> <p>a. Resident #7's medical record review revealed the resident was admitted to the facility on 3/26/12 with diagnoses which included: CVA (cerebral vascular accident) with hemaplegia affect on dominant side, delusional disorder, vascular dementia, contracture lower left leg, osteoporosis, esophageal reflux and edema.</p> <p>1) Review of resident #7's MDS (minimum data set) assessment on 12/2/14 identified the resident as the following:</p> <ul style="list-style-type: none"> -BIMS score of 7 indicating severe cognitive impairment, [TOTAL SCORE. The total possible BIMS score ranges from 00 to 15 with 13 - 15: cognitively intact, 08 - 12: moderately impaired and 00 - 07: severe impairment.] -Extensive assistance with all ADLs, -Receives scheduled Pain medication, -Receives antipsychotic and antidepressant medications. <p>2) Review of the "Progress Notes" identified that on 10/2/14 the resident had Seroquel dose increased from 12.5 mg to 25 mg for combative delusional behavior related to unspecified disturbance of conduct.</p> <p>3)Review of the MAR (medication administration record) showed the resident was currently on Seroquel 25 mg daily, Effexor 37.5</p>	F 309		
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F 309	<p>Continued From page 9 mg and Tylenol 650 mg TID.</p> <p>4) On 12/11/14 at 1:00 PM, an interview with the MDS coordinator confirmed that a PAINAD (pain assessment in advanced dementia) had not been completed for resident #7 prior to adjusting this resident's medication for behaviors.</p> <p>b. Resident #9's medical record review revealed the resident was admitted to the facility on 2/4/08 with diagnoses included: Alzheimer's disease, restless leg syndrome, arthritis, pain in joints (multiple sites) and edema.</p> <p>1) Review of resident #9's MDS (minimum data set) assessment on 9/16/14 identified the resident as the following:</p> <ul style="list-style-type: none"> -BIMS score of 3 indicating severe cognitive impairment, -Extensive assistance with all ADLs, -Antidepressant medications. <p>2) Review of the MAR (medication administration record) showed the resident's current medication included: Aricept 10 mg daily , Remeron 30 mg daily , Celexa 20 mg daily and Tylenol 325 mg PRN as needed for pain.</p> <p>3) Review of the resident's care plan dated 9/24/14 did not address the resident potential for pain. It did address the resident as having behavior symptom R/T (related to) Alzheimer's disease, depression and anxiety yelling out "help me , help me."</p>	F 309		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SCOTLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 130 6TH STREET SCOTLAND, SD 57059
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F 309	<p>Continued From page 10</p> <p>There was no indication that the resident was assessed using the PAINAD or that the behaviors could be caused from this resident having pain.</p> <p>REFERENCE: Professional Standards of Practice in Assessment of Pain:</p> <p>a. Fundamentals of Nursing, The Art & Science of Nursing Care, Fourth Edition, Taylor, Lillis, LeMone, Lippincott, 2001, Chapter 40: Comfort, page 1047-1055 indicates that a comprehensive pain assessment would identify the causes of pain, how intensely the pain was experienced, when the resident experienced the pain, which pain medication was most effective in relieving the pain, and how the pain affected other needs such as agitation and adequate sleep. Factors to assess would include</p> <ol style="list-style-type: none"> 1) The characteristics of the pain (location, duration, quantity, quality, chronology, aggravating factors, and alleviating factors), 2) The resident's physiologic response to the pain (vital signs, skin color, perspiration, pupil size, nausea, muscle tension and anxiety), 3) The resident's behavior responses (posture, gross motor activities, facial features and verbal expressions), and 4) Affective responses of the resident such as anxiety or depression. <p>Additionally the pain assessment should include how the pain experience affects the resident's interactions with others, how it interferes with activities of daily living, meaning of pain to the resident and the resident's expectations for pain relief. A system for comprehensive pain assessments should also include a means for assessment of pain in residents who are cognitively impaired and guides to validate pain</p>	F 309		
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<p>F 309</p> <p>F 314 SS=D</p>	<p>Continued From page 11</p> <p>cues and recognize pain when the resident is unable to verbalize pain.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, it was determined that the facility failed to implement appropriate, timely interventions to prevent the development of pressure ulcers for one of 10 sampled residents (#6). This resident was facility-assessed to be at risk for the development of pressure ulcers. The findings included:</p> <p>Reference: According to "Pressure Ulcers in Adults: Prediction and Prevention", U.S. Department of Health and Human Services, Clinical Practice Guideline, Number 3, "Any person at risk for developing a pressure ulcer should avoid uninterrupted sitting in any chair or wheelchair. The individual should be repositioned, shifting the points under pressure at least every hour or be put back to bed if consistent with overall patient management goals."</p>	<p>F 314 Pressure Ulcers</p> <p>F 309 Resident #6 will have nursing care and medical treatment as ordered to ensure healing of the coccyx pressure ulcer. On 12/10/14 resident #6 care plan was updated to include the focus of the having an actual pressure ulcer and interventions for treatment. A pain focus was also added to resident #6 care plan that same date.</p> <p>F 314 All residents will be identified for their risk of developing a pressure ulcer on admission/readmission, with a significant change in status, and with quarterly MDS assessments using the Braden Scale for Predicting Pressure Score Risk User Defined Assessment (UDA). Additions have been made to the facilities procedure Skin Assessment and Pressure Ulcer Prevention II.W.4d. If at risk with a score of 18 or below, then the Braden will be repeated weekly x4 and then quarterly thereafter. Each time a Braden is completed with a resulting score of 18 or below, the residents care plan will be reviewed by the nurse completing the Braden UDA to ensure appropriate interventions for pressure ulcer prevention are in place. A progress note (PN) will show this assessment has been done, and that the care plan has been reviewed. Risk factors, such as an acute illness or change in status, will be noted by the Quality of Life team which meets weekly, and will be considered when making the determination of a resident being susceptible to the development of a pressure sore. At risk residents will have a daily skin inspection by nursing assistants, and abnormal findings reported to the charge nurse. If a pressure ulcer develops, the care plan will be reviewed and updated promptly, the dietary manager will be notified, and daily monitoring will be done by a licensed nurse as per the procedure II.W.4d using the Wound Data Collection UDA daily and Wound RN Assessment UDA weekly. The potential for pain will also be evaluated at that time using the facilities procedure for Pain Data Collection and Assessment, and the care plan reviewed and updated accordingly.</p> <p>On January 6, 2015 an in-service will be done for all nursing staff using the Good Samaritan Society Procedure II.W.4d Skin Assessment and Pressure Ulcer Prevention, GSS II.W.4c Pressure Ulcer Management, GSS II.W.4b Pressure Ulcer Practice Guidelines, and on completion of the UDA's Wound Data Collection and RN Wound Assessment. Nursing will be instructed to document complete and thorough findings on the UDA's. Implementation of this updated procedure II.W.4d will follow this in-service.</p> <p>The director of nursing or designee will audit that any newly admitted or any readmitted resident has Braden UDA's done, and if at risk for skin concerns, that these are done weekly x4. In addition, the Director of Nursing Services or designee will audit those residents who are at risk, or who are acutely ill, to assure that measures are in place on the care plan to prevent skin breakdown. Measures include a positioning program, nutritional and hydration support, pressure relief or reduction devices, daily skin inspections by nursing assistants, and assessment of acute conditions for appropriate and timely treatment, management of chronic conditions, and incontinence management. These audits will be done weekly x4, and then monthly x3 with findings reported to the Quality Assurance Performance Improvement (QAPI) committee at their monthly meetings. If a pressure ulcer develops, the DNS or designee will audit on that situation to ensure that the care plan was updated timely with treatments ordered, and to ensure completeness of the Wound Data UDA and Wound RN Assessment UDA. These will be done weekly x4 and then monthly x3 with findings reported to the QAPI committee. The QAPI committee will determine at the time of the final reporting of the scheduled audits, if further interventions are needed to ensure compliance with pressure ulcer prevention. Date certain 1/20/15.</p>
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5102/02/15

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F 314	<p>Continued From page 12</p> <p>According to "Pressure Ulcer Treatment", U.S. Department of Health and Human Services, Clinical Practice Guideline, Number 15, the resident should have an individually prescribed seat cushion which will relieve or reduce pressure on bony prominences. Support surface and positioning needs should be assessed and reviewed regularly and determined by results of skin inspection, patient comfort, ability, and general state. Covering these support services with bed linens, towels or incontinent pads decreases their effectiveness for pressure relief.</p> <p>1. Resident #6's medical record review revealed the resident was admitted to the facility on 7/13/11 and had a readmission from the hospital on 10/17/13. The resident's diagnoses included: Alzheimer's disease, hypertension, chronic ischemic heart disease, asthma, diabetes, weight loss, constipation and edema.</p> <p>a. Review of resident #6's MDS (minimum data set) assessment on 11/11/14 identified the resident as the following:</p> <p>-BIMS (BRIEF INTERVIEW FOR MENTAL STATUS) score of 99 as unable to interview, [Use Code 99 if: The individual chooses not to participate, or 4 or more items were coded 0 because the individual chose not to answer or gave a nonsensical response. [Note: Nonsensical response means any response that is unrelated, incomprehensible, or incoherent; it is not informative with respect to the item being rated.]</p> <p>-Behaviors marked as "yes" (noted behaviors were swearing at staff and yelling "Help Me"),</p> <p>-Extensive assistance from staff with all ADL's</p>	F 314		

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F 314	<p>Continued From page 13 (activities of daily living),</p> <p>-Frequently incontinent of bowel and bladder,</p> <p>-Pain was marked as should be assessed with interview.</p> <p>b. Review of resident #6's "Progress Notes" identified the resident as having a facility acquired pressure sore as well as URI (upper respiratory infection) and weight loss. The notes included:</p> <p>11/25/18 "Provider aware of open area to coccyx. Orders noted for Kendall soothing ointment with zinc TID (three times per day)."</p> <p>11/17/13 high nutritional risk with history of weight loss identified. Staff provides extensive to total assist with all cares.</p> <p>11/3/14 Family notification that they were informed of dx (diagnosis) of URI (upper respiratory infection) and tx (treatment) which they agreed. This included antibiotics for 10 days.</p> <p>c. Review of the "Wound RN Assessment" documentation on 11/25/14 identified the resident as having a Stage II pressure ulcer on her coccyx.</p> <p>d. Review of the "Wound Data Collection" sheets dated 11/25/14 identified it as the initial data collection of the wound on the coccyx. The measurements were 1.0 in length, .4 in width and .1 in depth with no drainage present. The wound bed was listed as 100% granulation tissue and no undermining or tunneling present. The treatment was Kendall soothing ointment with Zinc. The wound documentation on 12/3/14 described the</p>	F 314		

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F 314	Continued From page 14 wound as length of .3 with no width or depth listed. e. On 12/10/14 the resident was observed seated in a wheelchair by the nurses station. The resident was noted to repeatedly attempt to lean forward and reposition her bottom in the wheelchair. At 11:45 AM Nurse H went to check on the resident. The resident did open her eyes but did not verbally respond to the Nurse. The nurse then reported that the resident did pull back as having discomfort when ointment was applied to her open area on the coccyx but the area was just about healed. The Nurse then had staff reposition the resident. The resident was noted to have a pressure reduction cushion in her wheelchair. f. Review of resident #6's care plan dated 11/18/14. It had not been updated after the resident developed the pressure sore on her coccyx on 11/25/14 to show what interventions were implemented to heal the pressure sore and prevent further skin breakdown.	F 314			
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based upon observation and staff interview on 12/11/2014 at 7:45 am it was determined that the facility failed to maintain a kitchen floor that was	F 465			

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F 465	Continued From page 15 free of damage. The kitchen floor in front of the Hobart Refrigerator was observed to be cracked and damaged and in need of repair or replacement. The damaged area measured 18 ft x 3 ft with areas that were uneven presenting a unsafe hazard for kitchen staff and other facility workers. This observation was also identified and observed by the Administrator and the Environmental Service Director.	F 465	F 465 Finding: Flooring in the kitchen is cracked and damaged and is considered to be a non-cleanable unsafe surface in the kitchen. Corrective Action: As of 12/22/14 three contractors have been contacted to provide Administrator with quotes of estimated floor replacement and completion time frame. These three quotes & bids to complete the flooring project will require a request for capital improvement through budget/financial department of the GSS National Campus. These quotes and bids will be completed and submitted for approval. Date certain 1/20/2015. With an estimated completion of floor replacement by May 31 st , 2015. The administrator will report to QA committee on a monthly basis on completion steps of the kitchen flooring up until the flooring has been replaced.	5102/102/11/2015	
F 516 SS=E	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based upon observation and staff interview on 12/11/14 between 10:15 and 10:30 AM it was determined that the facility failed to secure resident medical records. Resident medical records were found to be unsecured and at risk of being opened and read by anyone who sought resident personal history information. Findings include:	F 516 Finding: Resident medical records are not being stored in a secure manner. Medical records that are being stored outside and away from the facility are located in file cabinets that are located in the bus garage. The garage key is available to multiple staff to access. 2 of the 15 file cabinets are unable to be locked and others that were just left unlocked.			

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F 516	Continued From page 16 There were approximately 16 four drawer file cabinets stored in the bus garage adjacent to the nursing home. Six drawers were found to be unlocked when tested and files of expired resident medical information was easily obtained and viewed. There were also keys belonging to the file cabinets hanging on the back of the nursing home door that would have provided unlimited access to all the residents past and present personal information. The Administrator confirmed that anyone who had access to the garage or keys would have access to the medical records of those former residents.	F 516	Corrective Action: As of 12/26/14 all medical records located in the bus garage are in secured/locked file cabinets. There are no keys available to these file cabinets other than those located in the HIM & Administrator's offices. Audits will be conducted weekly X 4, and then monthly x3 to ensure all resident medical records are securely stored. Findings of these audits will be reported to the Quality Assurance Performance Improvement Committee (QAPI) at the monthly meetings. After review of the last of these scheduled audits, the QAPI committee will determine the need for any additional interventions of focused monitoring.	12/26/14 <i>[Signature]</i>	