

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10709	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2014
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NAME OF PROVIDER OR SUPPLIER AURORA-BRULE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 408 S. JOHNSTON ST WHITE LAKE, S.D., SD 57383
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S 000	Initial Comments <i>addendums noted with an asterisk per original telephone to facility DON and administrator. JK/SDDC-HMF</i> Surveyor: 32355 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 6/23/14 through 6/25/14. Aurora-Brule Nursing Home was found not in compliance with the following requirement: S290.	S 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state law. Without waiving the foregoing statement, the facility states that with respect to:	
S 290	44:04:07:02.04 FOOD SUPPLY An on-site supply of nonperishable foods adequate to meet the requirements of planned menus for three days must be maintained. This Rule is not met as evidenced by: Surveyor: 12218 Based on record review, observation, calculation, and interview, the provider failed to ensure: *A variety and an adequate supply of protein type non-perishable meat and meat substitute foods were available to meet the needs and requirements of a three day food supply for thirty-eight residents on oral diets. *There were three days of planned emergency menus, but no menu extensions for texture modified diets that coordinated with the requirements of the non-perishable food supply. Findings include: 1. Observation on 6/25/14 at 11:30 a.m. of the dry food storage area and the food supply with the certified dietary manager (CDM) revealed: *There was not enough variety of protein type non-perishable meat or meat substitute foods to meet the protein requirement (five ounces per	S 290	The Supply of nonperishable food for a three day planned menu was observed to ensure that the supply of food, including menu extensions for texture modified diets, and a sufficient amount of protein-type non perishable meat or meat substitute was adequate for the emergency three day menu. The Administrator and Dietary Manager reviewed and revised the policies and procedures of the emergency three day menu so that an adequate supply of nonperishable food, including menu extensions for texture modified diets, and a sufficient amount of protein-type non perishable meat or meat substitute will be maintained.	8/2/14

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

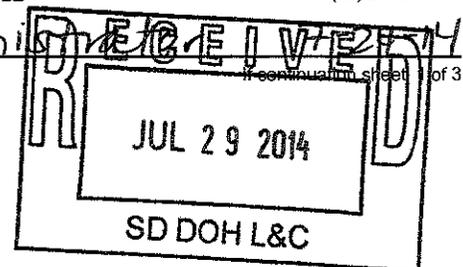
TITLE

(X6) DATE

STATE FORM

021198

Administrative
ERQM11



continuation sheet of 3

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S 290	Continued From Page 1 day) for all residents on oral diets for three days. *The provider had canned tuna, pork and beans, canned chicken, and peanut butter for protein choices. -A usual pattern for protein was one ounce at breakfast, two ounces at dinner, and two ounces at supper to equal five ounces of protein for the day to meet the minimum portion requirement. -A one ounce serving of meat or meat substitute equals seven grams (gm) of protein. -A usual entree two ounce serving at lunch or supper equaled fourteen grams of protein. *There was not enough two ounce servings of tuna (fish protein) for even one meal as there was only one package of tuna that contained twenty-two servings and not thirty-eight. *If a resident did not like tuna or pork and beans the choice was peanut butter for all meals on all three days. *If the resident who did not like fish was on a dysphagia or mechanical soft diet for swallowing or choking problems the peanut butter would not have been a good choice. The stickiness of the peanut butter could cause possible swallowing difficulties. Review of the three day emergency menu revealed: *Chili was planned for one evening meal, but there was no chili on hand. *Tuna was planned for two meals, and there was only one package of tuna that contained twenty-two servings which was not enough for even one meal. *There were no diet extensions planned on the emergency menus. *Portion sizes planned for the meat and meat substitute items of a number 8 (1/2 cup) were not adequate to provide the required amount of protein if included in the mixture.	S 290	The Dietary Manager or designee will audit the emergency three day menu supply of nonperishable foods once a week for one month and once a month for two more months to ensure that there is an adequate amount of food available for that menu including menu extensions for texture modified diets and non perishable meat or meat substitute. The Dietary Manager or designee will present the findings of the audit at the monthly QAPI meetings with further follow up as recommended by the committee. <i>*Audits will occur once a month by the dietary manager or designee. JK/SDDOH/MF</i>	

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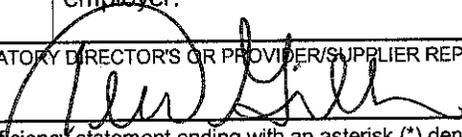
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S 290	Continued From Page 2 Interview with the CDM at that time revealed: *She had protein meat items on the order that were scheduled to come in Friday. *She had not been aware of some of the other types of canned meat items she could have included. *She was aware she did not have canned chili on hand. *She was aware she did not have enough tuna on hand. *She and her consultant dietitian would rewrite the emergency menus to include a variety of protein items and diet extensions.	S 290		

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F 000	<p><i>Additional items noted with asterisk per initial telephone to facility DON & Administrator. JKISSDOH IMF</i></p> <p>INITIAL COMMENTS Surveyor: 32355 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/23/14 through 6/25/14. Aurora-Brule Nursing Home was found not in compliance with the following requirements: F161, F225, F250, F281, F309, F315, F323, F386, and F441.</p>	F 000	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state law. Without waiving the foregoing statement, the facility states that with respect to:</p>	
F 161 SS=F	<p>483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS</p> <p>The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 12218 Based on record review and interview, the provider failed to ensure the one of one purchased surety bond assured the security of residents' personal funds that had been deposited with the provider. Findings include:</p> <p>1. Review of the provider's current surety bond premium due bill revealed: *It was paid up until 7/1/14. *It was in the amount of \$23,000.00 *It was a Western Surety Company Fidelity Bond.</p> <p>Review of the written information of what the bond covered revealed: *It covered the amount of any direct loss of moneys or other personal property of the employer.</p>	F 161	<p>Surety bond was reviewed to ensure the security of all personal funds of residents monies deposited with the facility. *</p> <p>Correction on the CMS2567, at the time of the survey, the amount of monies deposited with the facility was \$3,013.22. At the time the Plan of Correction was written, the amount remained at \$3,013.22.</p> <p>Administrator purchased a surety bond to ensure the security of all personal funds of residents monies deposited with the facility.</p> <p>The Administrator will audit the surety bond once a month for three months to ensure the security of all personal funds of resident's monies deposited with the facility.</p> <p><i>This affects all residents who currently have a trust account with the facility. The audits will be continuous monthly by the administrator. JKISSDOH IMF</i></p>	8/2/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 7-24-14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 10 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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 161	Continued From page 1 *It covered any employee while occupying any position named on the scheduled attached, who directed or by collusion caused to the employer. *Automatic coverage was granted for the first thirty days service of any employee. Interview with the administrator on 6/25/14 at 11:00 a.m. revealed: *She was not aware the provider's surety bond had not been written and purchased for the protection of residents' funds deposited with the provider. *She was unaware their surety bond was written as a Fidelity bond for protection of the employer and employees. *She was unaware they did not have a surety bond that protected the current amount of [REDACTED] of residents' funds deposited with the provider.	F 161	The Administrator will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.		
<i>x-2, 015, 201</i> <i>W/SUCH HOME</i> F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225	Employee D's file was reviewed to ensure that there had been an appropriate review of employee's application for pertinent information that may prohibit hire and appropriate review and understanding of what is reflected on the employee's background check. All other employee files were reviewed to ensure that there had been an appropriate review of employee's application for pertinent information that may prohibit hire and appropriate review and understanding of what is reflected on the employee's background check.	8/2/14	

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F 225	<p>Continued From page 2</p> <p>misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on employee file review, interview, and policy review, the provider failed to thoroughly follow-up on a background check with a pending theft charge and arrest warrant for one of five sampled employees (D). Findings include:</p> <p>1. Review of certified nursing assistant (CNA) D's employee file revealed: *A hire date of 4/15/14. *She had answered no when asked "Have you ever been convicted of a crime?" *No employer or reference checks had been done. *A background check from the South Dakota Unified Judicial System revealed the following:</p>	F 225	<p>The Administrator or Business Office Manager reviewed and revised the hiring policies and procedures so that they ensure the review of potential employee's application for pertinent information that may prohibit hire and appropriate review and understand of what is reflected on the employee's background check. Education on the updated policy and procedures will be provided to all staff responsible for the interview and hiring process.</p> <p>The Business Office Manager or designee will audit all new employee files once a month for three months to ensure that appropriate review of employee applications and backgrounds checks were completed upon hire.</p> <p>The Business Office Manager or designee will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.</p> <p><i>*The audits will be on-going and done monthly by the business manager. JK/SDDH/MF</i></p>	

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F 225	<p>Continued From page 3</p> <ul style="list-style-type: none"> -A pending case status filed on 4/4/14 with no details listed. -A pending case status on 2/10/14 for "Petty theft 2nd degree - \$400 or less." -A warrant history that stated "Issued on 2/10/14 for arrest warrant. Status: \$0.00 - Unsecured Bond Active - 2/10/14." -Nine other docket numbers (tracking system) from 2010 through 2014 that listed a variety of plaintiffs including the State of South Dakota. -Two other warrant histories for different offenses. <p>Interview, application review, and policy review on 6/25/14 at 3:15 p.m. and at 5:30 p.m. with the administrator revealed she:</p> <ul style="list-style-type: none"> *Had not known CNA D had marked no when asked "Have you ever been convicted of a crime?" *Had not followed-up on the two pending case statuses or the arrest warrant listed on the background check. *Believed the petty theft charge was because CNA D had written a bad check, but she had not asked her for the details regarding the situation. *Had not asked about the other nine cases listed from 2010 through 2014. *Had not had any training on how to interpret the background check. *Had not contacted prior employers of CNA D. *Had not documented any reference checks being completed. <p>Review of the provider's 7/15/13 Abuse Policy and Procedure policy revealed:</p> <ul style="list-style-type: none"> **DON [director of nursing] and/or administrator will be responsible for screening potential employees, requesting information from previous and/or current employees." **Criminal background checks will be done on all 	F 225		
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F 225	Continued From page 4 new employees." **"Fingerprints will be done, then sent to State DCI [division of criminal investigation]." **"The individual will not be hired until report is received from DCI agency." **"Potential employees with negative findings of background checks will not be hired."	F 225		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 A. Based on observation, record review, interview, policy review, and job description review, the provider failed to ensure medically necessary social services to intervene and advocate for one of three sampled residents (3) who was experiencing psychological stress, aggressive behaviors, and was potentially at risk for harm to self and others. Findings include: 1. Random observations from 6/23/14 through 6/25/14 of resident 3 revealed at times she had been resting quietly in her recliner, wandering up and down the halls, and going into other resident's rooms. She would occasionally holler out very loudly. Review of resident 3's medical record revealed: *An admission date of 7/15/13.	F 250	Resident 3 and 6's medical records were reviewed to ensure that medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial needs of those residents are being met. All other residents' medical records were reviewed to ensure that medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial needs of those residents are being met. The Administrator and Social Services Designee reviewed and revised as necessary the policies and procedures of the social services department to ensure that medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial needs of the residents are being met as well as the job duties within the job description as they relate to the individual resident cares and needs.	8/2/14

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F 250	<p>Continued From page 5</p> <p>*Diagnosis of dementia (forgetfulness), depression (feelings of hopelessness), falls, history of suicidal ideations (thoughts), abdominal aortic aneurysm (a bulging part of the aorta in the stomach), and diabetes mellitus (inability to control sugar levels in the blood).</p> <p>*She had impulsive and aggressive behaviors towards staff and other residents.</p> <p>*She could have Lorazepam (medication for anxiety) 0.5 milligrams (mg) every six hours as needed for agitation.</p> <p>Interview on 6/23/14 at 4:45 p.m. with certified nursing assistant (CNA) B regarding resident 3 revealed:</p> <p>*She was very confused and combative at times.</p> <p>*She had a history of biting, hitting, and kicking at staff during assistance with activities of daily living.</p> <p>*Her behaviors had been impulsive, quick, and not always avoidable.</p> <p>Review of resident 3's nurses' progress notes from 2/2/14 through 6/22/14 relevant to behaviors revealed on the following:</p> <p>*2/2/14 "Resident very anxious, wringing hands together. Going in and out of resident's rooms. Resident grabs other residents and staff."</p> <p>*2/7/14 she had punched the nurse in the throat during her insulin (medication to control sugar levels in the blood) administration.</p> <p>*2/8/14 she had lunged forward and charged at the nurse during assistance to move to another area.</p> <p>*2/17/14 "Resident grabbing at staff and other residents. Resident grabbed a male resident walking in hall and nearly knocked him down. At 8:30 p.m. two residents reported seeing resident 3 and another female resident slapping each</p>	F 250	<p>The Social Services Designee or designee will audit all residents' medical files once a month for three months to ensure that the facility is providing medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial needs of the residents.</p> <p>The Social Services Designee or designee will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.</p>	

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F 250	<p>Continued From page 6 other on 2 occasions." *2/18/14 "She has been very agitated and wound up all day. At 4:30 p.m. resident was holding on to another resident's wheelchair (w/c) and would not let go when he asked her to. Resident hit fellow resident on his right shoulder several times." *3/9/14 "Resident holding on to a visitor's arm and trying to reach his son when a certified nursing assistant (CNA) intervened and pulled her arm away from the visitor. Resident got very upset and started hitting CNA several times on her left shoulder and then slapped her on the left side of her face." Tylenol and Lorazepam had been given, but no results of the medication provided had been documented. *5/10/14 "Resident had a hold of another resident's w/c. The other resident and nurse had requested her to let the other resident go. Resident let go of the w/c and punched this nurse with her fist in the breast bone." *5/25/14 "Resident holding on to another resident's w/c. This nurse told resident she couldn't hand onto anybody. Resident slapped this nurse across the face." *6/17/14 she had kicked the nurse and slapped the CNA during personal care. *6/22/14 "Behaviors were very aggressive with HS (hours of sleep) cares. Slapping, hitting, punching, and kicking staff." *No documentation was found to support the primary physician had been notified of the above behaviors. *No documentation was found to support the need for outside consultation services for her behaviors.</p> <p>Review of resident 3's 9/3/14 care plan revealed: *A focus area of "Thought processes, impaired memory loss with diagnosis of dementia."</p>	F 250	<p>* As of 6/17/14 resident 3's Ativan has been rescheduled and is currently receiving counseling services from DCI in Mitchell with a psychiatry appointment scheduled on October 7, 2014. Avera Behavioral Health in Sioux Falls has been contacted about admittance and refused. On 6/17/14 Avera Behavioral Health sent the facility medication recommendations. These recommendations have been faxed to the primary doctor for review and further direction. JKSDDDHMF</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2014
NAME OF PROVIDER OR SUPPLIER AURORA-BRULE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383		
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F 250	<p>Continued From page 7</p> <p>*An approach area indicating the staff should have:</p> <ul style="list-style-type: none"> -Minimized distractions. -Eliminated distractions or background noise." <p>*A focus area of "Coping, impaired, individual anxious and restless. Episodes of combative behaviors."</p> <p>*An approach area indicating the staff should have:</p> <ul style="list-style-type: none"> -Administered the Lorazepam 0.5 mg every six hours as ordered. -"Provide close supervision and watch for early signs of agitation or increasing anxiety and report." <p>Review of resident 3's behavioral symptom charting for May and June 2014 revealed she had exhibited the above behaviors mentioned in the nurses documentation multiple times. No documentation was found to support any interventions had been attempted according to her care plan recommendations.</p> <p>Review of resident 3's 6/3/14 cognitive loss and behavioral symptoms charting by the SSD revealed:</p> <p>**_____ (Residents name) can become combative and is a risk for injury to herself and others."</p> <ul style="list-style-type: none"> *She can quickly become annoyed and strike out. *Busy and active environments can cause her to become more anxious. **"Her grasp is very firm and she puts others at risk of injury when she hold on to residents and walkers." *The Lorazepam had not been given as directed by the physician's orders for anxiety and agitation. *There had been only one referral, and that had been to the nursing department for medication 	F 250	<p>*A list of a assisted living centers in South Dakota that accepts Medicaid was obtained from the state social services office for Resident U. Resident U has recently been transferred to Meadows on Sycamore in Sioux Falls. JK/DDH/MF</p>		

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F 250	<p>Continued From page 8 administration.</p> <p>*There was no documentation to support the primary medical doctor had been notified of her behaviors.</p> <p>*There was no documentation to support the consideration for outside consultation services to assist her with her mental and psychological instability.</p> <p>Interview on 6/25/14 at 3:20 p.m. with the director of nursing (DON), SSD, and licensed practical nurse (LPN) C regarding resident 3 revealed:</p> <p>*They had been aware of her aggressive behaviors to staff and other residents as mentioned above.</p> <p>*There had been no consideration for outside services to help with her mental instability, psychological stress, and safety for self and others.</p> <p>*The medical doctor had not been consulted on her behaviors and significant change in status.</p> <p>*She had been at risk of injury to other residents, herself, and to the staff.</p> <p>*Due to her dementia and problems with memory, most non-pharmacological interventions had not been helpful.</p> <p>*The care plan had not been updated to reflect all of the interventions that had been attempted or used to calm her.</p> <p>*The Lorazepam had been effective for behavior control when given.</p> <p>*They were not sure why the medications had not been offered according to the physician's orders during times of increase in anxiety and agitation.</p> <p>*They had not considered other placement for her to see if a calm and more quiet environment was appropriate.</p> <p>Review of the provider's 10/5/12 Job Description</p>	F 250		

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F 250	<p>Continued From page 9 for Social Services Department policy revealed: *Social services was responsible for arranging services that would promote preservation and maximum functioning of the resident's emotional and mental health. **"Identify those residents needing mental health services." **"Arrange for mental health services as needed."</p> <p>Surveyor: 32335 B. Based on record review, interview, and policy review, the provider failed to ensure discussions about moving into an assisted living were documented in the medical record for one of one sampled residents (6) who wanted to be discharged. Findings include:</p> <p>1. Interview on 6/24/14 at 7:35 a.m. with resident 6 revealed: *She had been admitted into the facility in December 2013. *She had not wanted to be living in a nursing home. *She wanted to move into an assisted living center in Sioux Falls or Rapid City.</p> <p>Review of resident 6's medical record revealed: *She had been re-admitted on 12/26/13 due to a failed attempt at moving in with her sister. *She had returned to the facility after being in a detoxification center for alcohol abuse. *According to her 6/3/14 Minimum Data Set assessment she was independent in all activities of daily living except bathing. *The social services designee's (SSD) 1/7/14 admission assessment note stated " _____ [resident's name] does want to speak to someone about going to more independent living."</p>	F 250		

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F 250	<p>Continued From page 10</p> <p>*The SSD's 3/20/14 quarterly assessment note stated "SSD did contact adult services for a list of low income apartments." And "_____ [resident's name] still wants to talk to someone about living more independently."</p> <p>*The SSD's 6/6/14 quarterly assessment note stated "_____ [resident's name] still wants to talk to someone about living more independently but does understand SSD cannot get her an apartment or even rent a motel without having any income."</p> <p>*There was no documentation of her wanting to live in an assisted living center in Rapid City or Sioux Falls.</p> <p>*There were no referrals to assisted living centers.</p> <p>Interview on 6/25/14 at 5:00 p.m. with the SSD, administrator, and director of nursing regarding resident 6 revealed:</p> <p>*The SSD had been the one assisting her with her discharge plans.</p> <p>*The SSD had not felt independent living was an appropriate option for her after the failed attempt at moving in with her sister.</p> <p>*She had not wanted to live in an assisted living center until recently.</p> <p>*The SSD had not documented any of the conversations she had with the resident about moving to an assisted living center.</p> <p>*There had been no referrals to an assisted living center as the SSD was helping her with her financial situation.</p> <p>Review of the provider's 11/9/11 Documentation Policy revealed "documentation will be charted clear and objectively and must be accurate, legible, concise, continuous, and complete."</p>	F 250			

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F 281 F 281 SS=E	Continued From page 11 483.20(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: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Appropriate labeling and transcription occurred for two of two insulin order changes for one of two observed residents (11) receiving insulin (medication to control sugar levels in the blood) administration. *Direction changes occurred on two pharmacy labels for a controlled and highly diverted (stolen) medication for one of four sampled and random residents (14) who received a scheduled III (medic: are tightly ← Spellings/VA *Order re transcri medication adminis vo samplex ulant (blood tl *Clarific: ed for one of n ng calcium antacid medication. *Documentation and physician clarification occurred for the timeliness of medication administration for one of one sampled resident (7) on dialysis (process for cleaning the resident's blood) services. *Documentation and assessment occurred on the patency (open or unobstructed) of a hemodialysis catheter (tube inserted underneath of the skin to	F 281 F 281	Resident 11, 14, 5, and 7's Medication Administration Record was reviewed to ensure that appropriate labeling and transcription occurred so that it meets professional standards of care and reflected the current physician's orders. All other residents' medication administration record was reviewed to ensure that appropriate labeling and transcription occurred so that it meets professional standards of care and reflected the current physician's orders. Resident 8's oxygen concentrator had been observed to ensure proper replacement of the humidifier canister and that the humidifier canister was filled with distilled water each time the resident was using the oxygen concentrator. All other residents using oxygen concentrators had been observed to ensure proper replacement of the humidifier canister and that the oxygen concentrator's humidifier canister was filled with distilled water each time they were in use.	8/2/14

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F 281	<p>Continued From page 12</p> <p>assist with the cleansing of the blood) for one of one sampled resident (7) receiving dialysis services.</p> <p>*Humidity was provided for two of two sampled residents (5 and 8) receiving oxygen therapy. Findings include:</p> <p>1. Review of resident 11's medical record revealed:</p> <p>*A diagnosis of diabetes (inability to use sugar in the body without medication).</p> <p>*A 5/7/14 physician's order for:</p> <p>-Levemir (insulin medication used to control blood sugar levels in the blood) 55 units subcutaneous (SQ) (injection underneath the skin) twice a day (BID) before meals.</p> <p>-Novolog (insulin medication used to control blood sugar levels in the blood) 20 units SQ before meals.</p> <p>Observation on 6/24/14 at 7:55 a.m. of registered nurse (RN) A preparing to administer to resident 11 revealed:</p> <p>*She had retrieved the pharmacy label on the directions for the nursing units of the Levemir to</p> <p>*Resident 11's MAR had read Novolog insulin 15 units to be administered SQ three times a day</p> <p><i>S/b through/wk</i> ←</p> <p><i>draw</i> ↓</p>	F 281	<p>The Administrator and Director of Nursing reviewed and revised the medication administration policies and procedures to ensure that appropriate labeling and transcription occurs so that it meets professional standards of care and reflects the current physician's orders.</p> <p>The Administrator and Director of Nursing also reviewed and revised the use of oxygen concentrators policies and procedures to ensure that proper maintenance and replacement of the humidifier canisters and that the humidifier canisters were filled with distilled water when they are in use.</p> <p>Education on the newly reviewed and revised medication administration and oxygen concentrator policies was provided to the staff responsible for the tasks.</p> <p>The Director of Nursing or designee will audit the medication administration record for all residents twice a month for two months and once a month for one month to ensure that appropriate labeling and transcription occurs so that it meets professional standards of care and that they reflect the current physician's orders</p>		

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F 281	<p>Continued From page 13 (TID). The 15 had a pen line drawn through the number 20 written below it. ← <i>through/ins</i></p> <p>*She had retrieved an insulin syringe and drew 20 units of insulin from the Novolog vial.</p> <p>Interview and observation on 6/24/15 at the time of the above observation with RN A revealed: *The line drawn through the numbers on the MAR indicated a medication change had occurred. *She had not been sure when the insulin order changes for the Levemir and Novolog had occurred. *She had stated "The orders changed a while ago." "I could check the order changes if you want me to." *She had not been sure who had received the order changes for the Levemir and Novolog insulins. They should have notified the pharmacy of the changes so the correct order had been printed on this months MAR. *The new orders had not been transcribed correctly on this months MAR. *The orders should have been high lighted with a yellow marker indicating an order change. The new orders should have been re-written on the MAR. *The insulin vials should have had a label added to them indicating an order change. At the time of this interview she added the labels. *She proceeded to administer the insulin she had drawn up in the syringes to resident 11. *She had not clarified the order changes for the insulins prior to administering the insulins to the resident.</p> <p>Interview on 6/24/14 at 2:50 p.m. with the director of nursing (DON) revealed: *The new orders for the insulin dosage changes had not been changed correctly on the MAR.</p>	<p>Director of Nursing or designee will check all concentrators in use once a week for four weeks and twice a month for two months thereafter to ensure that proper maintenance and replacement of the humidifier canisters and that the humidifier canisters are filled with distilled water each time they are in use.</p> <p>The Director of Nursing or designee will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.</p> <p><i>* Resident 7s calcium and Renvela orders were clarified by the primary physician on 6/27/14. JK/SDDH/MF</i></p> <p><i>*The correct dose of Resident 6s Coumadin was in the card. The correct order was transcribed onto the medication administration MAR on 6/26/14. JK/SDDH/MF</i></p> <p><i>* A change of directions label was placed on Resident 11s insulin on 6/25/14. JK/SDDH/MF</i></p>	

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F 281	<p>Continued From page 14</p> <p>*The new orders should have been re-written on the MAR to clarify a change for any staff member administering the medication.</p> <p>*RN A should have clarified the physician's orders prior to administering the insulin.</p> <p>2. Observation on 6/25/14 at 10:30 a.m. of a schedule III medication revealed:</p> <p>*Resident 14 had two blister packs (pre-formed plastic packaging) for hydrocodone-APAP (acetaminophen) (controlled medication for pain) 5/325 milligrams (mg).</p> <p>*The pharmacy labels and directions on both of her blister packs had not been identical. The pharmacy labels had read the following:</p> <p>-Blister pack 1 had read "Give 1 tablet by mouth every 1-2 hours as needed prior to bath."</p> <p>-Blister pack 2 had read "Give 1 tablet by mouth three times daily (5am-12pm-5pm)..give 1 tablet by mouth every 1-2 hours as needed."</p> <p>*There had been no sticker on the medication cards indicating an order or dosage change had occurred.</p> <p>*Review of resident 14's MAR for June 2014 revealed she was to have received one hydrocodone 5/325 mg tablet TID and as needed (PRN).</p> <p>Interview on 6/25/14 at the time of the observation with the DON revealed:</p> <p>*Resident 14 had recently been placed on hospice (comfort care) and the hydrocodone orders had changed on 6/9/14.</p> <p>*She had been receiving the hydrocodone PRN prior to her condition change.</p> <p>*The nurses had retrieved resident 14's two PRN cards and were using those in place of ordering new hydrocodone blister packs.</p> <p>*There should have been a sticker placed on the</p>	F 281	<p>* New cards were issued on 6/25/14 for Resident 14 JK/SDDOH/MF</p> <p>* Education has been provided to the nursing department on policies and oxygen on 7/1/14. JK/SDDOH/MF</p>		

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F 281	<p>Continued From page 15 medication cards indicating a dosage and order change had occurred.</p> <p>Review of the provider's 2/3/14 General Medication Administration Policy and Procedure revealed: **"During the medication pass nursing should always check the 6 R's: Right resident, right drug, right dose, right dosage form, right time, and right route." **"If there is a discrepancy between the card, label and MAR, hold the medication until the medication pass is completed and verify with the Physician's order sheet."</p> <p>Surveyor: 32335 3. Review of resident 5's physician telephone orders revealed: *On 5/29/14 an order for: -Coumadin (blood thinning medication) 5 milligrams (mg) on Monday and Friday. -Coumadin 4 mg on Tuesday, Wednesday, Thursday, Saturday, and Sunday. -To recheck levels on 6/11/14.</p> <p>Review of resident 5's June 2014 MARs revealed: *From 6/1/14 through 6/5/14 an order for warfarin sodium (generic name for Coumadin) 4 mg tablet once daily at 8 p.m. *To recheck levels on 5/28/14. *That had not matched the above telephone order. *A note that stated "transcription error rewritten 6/6/14."</p> <p>Review of resident 5's June 2014 pharmacy consultation report revealed on 6/6/14 the pharmacist had identified the 5/29/14 order had not been added to the June 2014 MAR.</p>	F 281			

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F 281	Continued From page 16 Interview and record review on 6/25/14 at 10:00 a.m. with the DON regarding resident 5's medications revealed: *Staff had not transcribed the correct order for the Coumadin onto the June 2014 MAR. *The pharmacist had double checked the medication packs and verified the correct doses had been given. *Staff had not verified the label against the MAR before giving the blood thinning medication on 6/1/14 through 6/5/14. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 590, revealed: **Nurses and pharmacists check all medication orders for accuracy and thoroughness several times during the transcription process." **Each time a medication dose is prepared, the nurse refers to the MAR." Surveyor: 33265 4 a. Review of resident 7's complete medical record revealed: *A physician's order dated 5/22/14 for the following medication on the day of admission on 5/22/14 to the facility: *Calcium antacid 500 milligrams (unit of measure), give one tablet by mouth as directed. *That order was incomplete and did not provide the needed direction on how often or when to give the tablet. *The order was not clarified by nursing staff. *The medication had not been given during the month of June.	F 281		

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F 281	<p>Continued From page 17</p> <p>Interview on 6/25/14 at 3:00 p.m. with the DON revealed she would have expected the nursing staff to have clarified the order for the calcium antacid.</p> <p>Review of Ruth F. Craven and Constance J. Hirnie, Fundamentals of Nursing, 6th Ed., Lippincott Williams & Wilkins, Philadelphia, PA, 2009, page 502 revealed "Always clarify with the prescriber any medication order that is unclear or seems inappropriate."</p> <p>b. A physician's order dated 5/23/14 for the following medication: *Renvela, 800 mg tablets, three tablets, three times a day. *On 5/23/14 the infection control nurse requested clarification from the physician concerning this medication. She used a previous set of instructions from another facility's medication list. The previous instructions were for three tablets, three times a day with meals, and one tablet with snacks. *On 5/23/14 the physician responded to the request for clarification and ordered three tablets three times a day. *Written on the June MAR was three tablets, four times a day not three times a day. *This medication had been scheduled for different times on three days a week without an explanation.</p> <p>Interview on 6/25/14 at 3:00 p.m. with the DON revealed she expected the nursing staff to: *Not place other facility's medication lists under the physician order section of the medical record. *Follow physicians' orders for medications correctly. *Clarify medication orders concerning dialysis</p>	F 281			

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F 281	<p>Continued From page 18 schedule and document the results of the conversation.</p> <p>Review of Ruth F. Craven and Constance J. Hirnle, Fundamentals of Nursing, 6th Ed., Lippincott Williams & Wilkins, Philadelphia, PA, 2009, revealed: *Page 204: "Entries must be accurate." *Page 216: The medication administration record "must be updated regularly in accord with changes in the client's [resident's] medications and patterns of use."</p> <p>c. A physician's order dated 5/23/14 for the assessment of bruit (dialysis access site) every shift was not signed on the treatment administration record as having been done by the nursing staff on 6/4/14 and 6/19/14.</p> <p>Interview on 6/25/14 at 3:00 p.m. with the DON revealed she expected: *The bruit to be assessed every shift as ordered. *The nursing staff members to document assessment was completed on treatment record.</p> <p>Review of Ruth F. Craven and Constance J. Hirnle, Fundamentals of Nursing, 6th Ed., Lippincott Williams & Wilkins, Philadelphia, PA, 2009, revealed on page 203: **"As an instrument of continuous client care and as a legal document, the client [resident] record should contain all pertinent assessments, planning, interventions, and evaluations for that client." **"Nurses' entries on the client record are important because they show medical and nursing orders carried out."</p>	F 281		

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F 281	<p>Continued From page 19 Surveyor: 12218 5. Observation on 6/25/14 at 8:30 a.m. of resident 8's oxygen concentrator in her room revealed the humidifier canister was empty. Resident 8 was in the dining room using a nasal cannula at that time.</p> <p>Review of resident 8's medical record revealed: *She was to have O2 continuous for shortness of breath. *It was to run at 3 liters. *The nasal cannula was to be used to keep her oxygen saturations above 90 percent. *Oxygen levels were checked twice a day. *Her oxygen levels could drop quickly as she did not always leave her oxygen on.</p> <p>Observation on 6/25/14 at 3:45 p.m. of resident 8 revealed: *She was in her room using the oxygen concentrator. *The humidifier canister was empty.</p> <p>Observation on 6/25/14 at 4:00 p.m. of resident 8 in her room and interview with the director of nursing (DON) revealed: *She was sitting in her wheelchair eating popcorn. *She was hooked up to her oxygen concentrator. *The humidifier canister was empty. *The DON confirmed it was empty. *The DON stated: -The humidifier canister should always be checked by the staff each time the resident was using the oxygen concentrator. -It should have been filled with distilled water ^{sp.} distilled wa</p> <p>Observation and interview on 6/23/14 at 4 p.m. with resident 5 revealed: *An oxygen concentrator in her room.</p>	F 281		

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F 281	Continued From page 20 *The concentrator was running. *The tubing was lying on the floor. *The humidifier canister did not have water in it and had a date of 6/14/14 on it. *She only used the oxygen at night when she was sleeping. *Staff took care of the machine. *She did not know how to turn it on or off. Interview on 6/25/14 at 10:30 a.m. with the infection control nurse revealed: *There should have been water in the humidifier. *The water should never have gotten below a certain line on the canister. *Each shift was responsible for checking the water in the canisters. *The canisters were supposed to be replaced every fourteen days. *The canister should have been changed on 6/22/14, so there should have been water in the canister on 6/23/14. Review of the provider's October 2011 Oxygen Concentrator Maintenance policy revealed "if a humidifier is utilized, the jar will be filled with fresh, distilled water, as needed."	F 281		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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.	F 309	Resident 3's medical record was reviewed to ensure that the resident was provided with 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.	8/2/14

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F 309	<p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355</p> <p>A. Based on observation, interview, record review, policy review, and job description review, the provider failed to:</p> <ul style="list-style-type: none"> *Provide medically necessary social services to intervene and advocate for one of three sampled residents (3) who was experiencing psychological stress, aggressive behaviors, and was potentially at risk for harm to self and others. *Provide medically necessary nursing services to appropriately monitor, identify interventions, administer medications according to the physician's orders, notify the physician of significant changes, and refer to outside consultation for one of three sampled residents (3) who was experiencing psychological stress. *Follow and update as needed one of three sampled resident's (3) care plan who was experiencing psychological stress. <p>Findings include:</p> <p>1. Random observations from 6/23/14 through 6/25/14 of resident 3 revealed at times she had been resting quietly in her recliner, wandering up and down the halls, and going into other resident's rooms. She would occasionally holler out very loudly.</p> <p>Review of resident 3's medical record revealed:</p> <ul style="list-style-type: none"> *An admission date of 7/15/13. *Diagnosis of dementia (forgetfulness), depression (feelings of hopelessness), falls, history of suicidal ideations (thoughts), abdominal aortic aneurysm (a bulging part of the aorta in the stomach), and diabetes mellitus (inability to control sugar levels in the blood). *She had impulsive and aggressive behaviors 	F 309	<p>All other residents' medical records were reviewed to ensure that they are provided with 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>The Administrator, Director of Nursing, Medical Director, interdisciplinary team and Social Services Designee reviewed the policies and procedures of social services and the job descriptions of those employees providing social services to ensure that the residents are provided with 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>All staff will be educated on the reviewed and revised policies and procedures for attaining and maintaining the highest practicable physical, mental and psychological well-being of each and every resident as well as being able to monitor and identify these factors.</p>	
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F 309	<p>Continued From page 22 towards staff and other residents. *She could have Lorazepam (medication for anxiety) 0.5 milligrams (mg) every six hours as needed for agitation.</p> <p>Interview on 6/23/14 at 4:45 p.m. with certified nursing assistant (CNA) B regarding resident 3 revealed: *She was very confused and combative at times. *She had a history of biting, hitting, and kicking at staff during assistance with activities of daily living. *Her behaviors had been impulsive, quick, and not always avoidable.</p> <p>Review of resident 3's nurses' progress notes from 2/2/14 through 6/22/14 relevant to behaviors revealed on the following: *2/2/14 "Resident very anxious, wringing hands together. Going in and out of resident's rooms. Resident grabs other residents and staff." *2/7/14 she had punched the nurse in the throat during her insulin (medication to control sugar levels in the blood) administration. *2/8/14 she had lunged forward and charged at the nurse during assistance to move to another area. *2/17/14 "Resident grabbing at staff and other residents. Resident grabbed a male resident walking in hall and nearly knocked him down. At 8:30 p.m. two residents reported seeing resident 3 and another female resident slapping each other on 2 occasions." *2/18/14 "She has been very agitated and wound up all day. At 4:30 p.m. resident was holding on to another resident's wheelchair (w/c) and would not let go when he asked her to. Resident hit fellow resident on his right shoulder several times." *3/9/14 "Resident holding on to a visitor's arm</p>	F 309	<p>The Social Services Designee or other designee will audit the medical records for all residents twice a month for 2 months and once a month for 1 month to ensure the identification and response to inappropriate resident behavior and psychological stress, identification of interventions for residents inappropriate behavior and psychological stress thus ensuring that the residents are provided with 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>The Social Services Designee or other designee will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.</p> <p>Resident 7's medical record was reviewed to ensure the planning of care, the education of employees, and the contract agreement with the dialysis provider occurred for this resident receiving dialysis services.</p>		

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F 309	<p>Continued From page 24</p> <p>*An approach area indicating the staff should have: -Administered the Lorazepam 0.5 mg every six hours as ordered. -"Provide close supervision and watch for early signs of agitation or increasing anxiety and report."</p> <p>Review of resident 3's behavioral symptom charting for May and June 2014 revealed she had exhibited the above behaviors mentioned in the nurses documentation multiple times. No documentation was found to support any interventions had been attempted according to her care plan recommendations.</p> <p>Review of resident 3's 3/11/14 and 5/29/14 Minimum Data Set (MDS) nursing progress notes revealed: *She had a history of aggressive behaviors toward other residents. *"_____(residents name) continues to wander in halls in her w/c, sometimes grabs hold of back of others in w/c and it has upset a few of these residents, sometimes even causing more confusion/frustration for the one she has grabbed a hold of, we do continue to monitor for these situations." ***She also has had confrontations with other residents that have turned into being physical." *She continued to have the Lorazepam every six hours as needed. *No documentation was found to support any interventions had been attempted by the staff to calm her or help her during times of discomfort and anxiety. *No documentation was found to support any referrals to the social services designee (SSD), primary medical doctor, or to outside services to</p>	F 309	<p>All other residents receiving hospice services had their medical records reviewed to ensure that the resident's care plan and the hospice's care plan were integrated for those residents.</p> <p>The Administrator and Director of Nursing reviewed and revised the policies and procedures of Hospice services so that they include the integration of both the hospice's care plan and the facility's care plan for those residents receiving hospice services.</p> <p>The Director of Nursing or designee will audit all residents receiving hospice services twice a month for one month and once a month for two more months to ensure the integration of both the resident's care plan and the hospice's care plan.</p> <p>The Director of Nursing or designee will present the findings of the audit at the monthly QAPI meetings with further follow up as recommended by the committee.</p>	

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F 309	Continued From page 23 and trying to reach his son when a certified nursing assistant (CNA) intervened and pulled her arm away from the visitor. Resident got very upset and started hitting CNA several times on her left shoulder and then slapped her on the left side of her face." Tylenol and Lorazepam had been given, but no results of the medication provided had been documented. *5/10/14 "Resident had a hold of another resident's w/c. The other resident and nurse had requested her to let the other resident go. Resident let go of the w/c and punched this nurse with her fist in the breast bone." *5/25/14 "Resident holding on to another resident's w/c. This nurse told resident she couldn't hand onto anybody. Resident slapped this nurse across the face." *6/17/14 she had kicked the nurse and slapped the CNA during personal care. *6/22/14 "Behaviors were very aggressive with HS (hours of sleep) cares. Slapping, hitting, punching, and kicking staff." *No documentation was found to support the primary physician had been notified of the above behaviors. *No documentation was found to support the need for outside consultation services for her behaviors. Review of resident 3's 9/3/14 care plan revealed: *A focus area of "Thought processes, impaired memory loss with diagnosis of dementia." *An approach area indicating the staff should have: -Minimized distractions. -Eliminated distractions or background noise." *A focus area of "Coping, impaired, individual anxious and restless. Episodes of combative behaviors."	F 309	All other residents' medical records were reviewed for those receiving dialysis services to ensure the planning of care, the education of employees, and the contract agreement with the dialysis provider occurred. The Administrator and Director of Nursing reviewed and revised the policies of dialysis services so that they include the planning of care, the education of staff, and the contract agreement with the dialysis provider. The Director of Nursing or designee will audit once a month for three months all residents receiving dialysis services to ensure the planning of care, the education of staff, and the contract agreement with the dialysis provider has occurred. The Director of Nursing or designee will present the findings of the audits at the monthly QAPI meetings with further follow up recommended by the committee. Resident 8's medical record was reviewed to ensure that the resident's care plan and the hospice's care plan were integrated for this resident on hospice.	

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F 309	<p>Continued From page 25</p> <p>help support her ongoing mental instability, psychological stress, and safety concerns for self and others.</p> <p>Review of resident 3's 6/3/14 cognitive loss and behavioral symptoms charting by the SSD revealed: **_____ (Residents name) can become combative and is a risk for injury to herself and others." *She can quickly become annoyed and strike out. *Busy and active environments can cause her to become more anxious. **Her grasp is very firm and she puts others at risk of injury when she hold on to residents and walkers." *The Lorazepam had not been given as directed by the physician's orders for anxiety and agitation. *There had been only one referral, and that had been to the nursing department for medication administration. *There was no documentation to support the primary medical doctor had been notified of her behaviors. *There was no documentation to support the consideration for outside consultation services to assist her with her mental and psychological instability.</p> <p>Review of resident 3's medication administration record (MAR) from 3/1/14 through 6/24/14 revealed: *During March she had been offered the Lorazepam 0.5 mg 6 times. The effectiveness and acceptance of the medication had not been charted. She could have received the medication 124 times March. *During April she had been offered Lorazepam 0.5 mg once. No documentation had been found</p>	F 309	<p>* AS of 6/11/14 Resident 3's Ativan has been rescheduled and is currently receiving counseling services from DCI in Mitchell with a psychiatry appointment scheduled on October 7, 2014. Avera Behavioral Health in Sioux Falls has been contacted about admittance and refused. On 6/11/14, Avera Behavioral Health sent the facility medication recommendations for resident 3. These recommendations have been faxed to the primary doctor for review and further direction. JASDD/ALMF</p>	
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F 309	<p>Continued From page 26</p> <p>to support the effectiveness or acceptance of the medication. She could have received the medication 112 times during April.</p> <p>*During May she had been offered Lorazepam 0.5 mg once. There had been no documentation to support the effectiveness of the medication. She could have received the medication 124 times May.</p> <p>*During June she had been offered Lorazepam 0.5 mg twice. There had been documentation only once to support the medication had not been effective.</p> <p>Interview on 6/25/14 at 3:20 p.m. with the director of nursing (DON), SSD, and licensed practical nurse (LPN) C regarding resident 3 revealed:</p> <p>*They had been aware of her aggressive behaviors to staff and other residents as mentioned above.</p> <p>*There had been no consideration for outside services to help with her mental instability, psychological stress, and safety for self and others.</p> <p>*The medical doctor had not been consulted on her behaviors and significant change in status.</p> <p>*She had been at risk of injury to other residents, herself, and to the staff.</p> <p>*Due to her dementia and problems with memory, most non-pharmacological interventions had not been helpful.</p> <p>*The care plan had not been updated to reflect all of the interventions that had been attempted or used to calm her.</p> <p>*The Lorazepam had been effective for behavior control when given.</p> <p>*They were not sure why the medications had not been offered according to the physician's orders during times of increase in anxiety and agitation.</p> <p>*They had not considered other placement for her</p>	F 309	<p>* A dialysis contract was received and signed on 7/29/14 for Resident 7. The dialysis provider will be in the facility on August 14, 2014 to provide education to the nursing and dietary departments. JK/SSDDO/HMF</p> <p>* Resident 8's hospice care plan was integrated with the facility care plan on 7/28/14. JK/SSDDO/HMF</p> <p>* Audits will continue to occur quarterly with the MSS assessments. JK/SSDDO/HMF</p> <p>* Education was provided to the nursing department on 7/29/14. JK/SSDDO/HMF</p>	

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F 309	<p>Continued From page 27</p> <p>to see if a calm and more quiet environment was appropriate.</p> <p>Review of the provider's 2/8/14 Behavioral Interventions policy revealed: *The definition of non-pharmacological approaches. *The definition of distressed behavior. **CNAs will document any behaviors noted during their shift on the behavior/mood monitoring log. Any interventions that were attempted will be documented on the behavior intervention sheet." *No further processes or procedures for behavioral management had been provided.</p> <p>Review of the provider's 10/5/12 Job Description for Social Services Department policy revealed: *Social services was responsible for arranging services that would promote preservation and maximum functioning of the resident's emotional and mental health. **Identify those residents needing mental health services." **Arrange for mental health services as needed."</p> <p>Surveyor: 33265 B. Based on interview and record review, the provider failed to ensure planning of care, education of employees, and contract agreement with the dialysis provider occurred for one of one sampled resident (7) receiving dialysis services. Findings include:</p> <p>1. Review of resident 7's complete medical record revealed: *An admission date of 5/22/14. *He had routinely received dialysis services three</p>	F 309		

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F 309	<p>Continued From page 28</p> <p>times a week since being admitted.</p> <p>*The care plan dated 6/10/14 had not:</p> <ul style="list-style-type: none"> -Addressed emergency procedures for possible bleeding from the dialysis access site. -Identified how to care for the arm where the dialysis access site was located. -Identified the resident's preference for taking a sack lunch along to dialysis or having lunch immediately upon returning from dialysis. <p>Interview on 6/25/14 at 3:00 p.m. with the director of nursing regarding resident 7 revealed:</p> <ul style="list-style-type: none"> *She agreed the care plan was missing some of the special needs of a person on dialysis. *She had talked to the certified nursing assistants about not doing blood pressures in the arm where the dialysis access site was located. There was no documentation of training for the nursing and dietary staff regarding the special needs of a dialysis resident which would have included: <ul style="list-style-type: none"> -How to assess and assure continued blood flow through dialysis access site. -Assessment and response to bleeding from dialysis access site. -Who to contact for emergencies concerning the dialysis access site. -Care of the arm where the dialysis access site was located. -Assuring resident did not miss meals while at dialysis. *There was no contract agreement with the dialysis provider since the resident had been admitted. <p>Review of the provider's May 2014 Care of Resident with End Stage Renal Disease policy revealed:</p> <ul style="list-style-type: none"> *No blood pressures were to be taken on the access arm. 	F 309			

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F 309	<p>Continued From page 29</p> <p>*The staff were not to use the access site arm to take blood samples, administer intravenous (through the vein) fluids, or give injections.</p> <p>*Dressings placed after dialysis were to be removed or changed as directed by dialysis center staff.</p> <p>*Mild bleeding from site after dialysis would be expected.</p> <p>*Major bleeding from the site after dialysis was a medical emergency and staff were to:</p> <ul style="list-style-type: none"> -Apply pressure to site. -Contact emergency services and the dialysis center. -Do not leave the resident alone. <p>Surveyor: 12218</p> <p>C. Based on record review and interview, the provider failed to ensure the resident's care plan and the hospice's care plan were integrated for one of one (8) sampled resident on hospice. Findings include:</p> <p>1. Review of resident 8's medical record revealed:</p> <ul style="list-style-type: none"> *She had been hospitalized from 6/1/14 to 6/5/14. with congestive heart failure, COPD (chronic obstructive pulmonary disease), pleural effusion, and anemia. *She had been admitted to hospice on 6/9/14 with the principla diagnosis of congestive heart failure, and other pertinent diagnosis of chronic airway obstruction, diabetes mellitus, type II, and alzheimer's disease. <p>Review of resident 8's most current care plan updated on 6/18/14 after she had gone on hospice revealed:</p> <ul style="list-style-type: none"> *The first time it was mentioned the resident was 	F 309		

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F 309	<p>Continued From page 30</p> <p>on Hospice was under the approaches for problem 3 on page 1 of 6.</p> <p>*Problem 3: "Thought process impaired, memory loss, Alzheimer's disease, cognition decline, room change, episodes of confusion and low O2 (oxygen) sats at times, continues to recognize self and family."</p> <p>*Goals for problem 3: "Will remain alert to self and family, will be able to state the year next quarter, see social services interdisciplinary notes."</p> <p>*Approaches for problem 3:</p> <p>-(1) "Keep name on door and picture beside door."</p> <p>-(2) "Provide calendar in room and keep on correct month."</p> <p>-(3) "Minimize distraction."</p> <p>-(4) "Use patient repetition."</p> <p>-(5) "Correct misconceptions and provide correct information in a kind and gentle manner."</p> <p>-(6) "Open curtains during day for day night RO, report changes in condition and increase confusion, contact Hospice if less alert or if lethargic."</p> <p>Continued review of resident 8's care plan revealed the second time hospice was mentioned was under problem 4 on page 3 of 6:</p> <p>*Problem 4: "Coping, impaired, individual unhappy with staff and care at times, diagnosis of depression, resistive and combative at times, taunts and torments other residents, doesn't leave O2 on at times and sats drop, health declining, admitted to Hospice. (no date was stated for admission to hospice)."</p> <p>*Goals: "Will continue to enjoy going outside when weather permits, will continue to attend non-denominational church services, will continue to have frequent visits from Hospice and the</p>	F 309		

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F 309	Continued From page 31 Hospice chaplain." *Under approaches: there were no references made to hospice or interaction with hospice. Interview on 6/25/14 at 2:30 p.m. with the director of nursing (DON) and LPN C revealed: *The hospice nurse had attended resident 9's care conference on 6/18/14. *The hospice nurse planned to provide a plan of care for resident 8. *They confirmed the provider's care plan and the hospice's care plan had not been integrated yet.	F 309			
F 315 SS=E	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 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. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to appropriately evaluate, assess, and create individualized toileting programs for five of five sampled residents (1, 2, 3, 6, and 8) with urinary incontinence concerns. Findings include: 1. Review of resident 6's 6/3/14 quarterly	F 315	Residents 1, 2, 3, 6, and 8's medical records were reviewed to ensure appropriate evaluation and assessments had been completed and individualization of the toileting programs to help restore as much normal bladder function as possible for these residents with urinary incontinence concerns. All other residents' medical records were reviewed to ensure appropriate evaluation and assessments had been completed and individualization of the toileting programs to help restore as much normal bladder function as possible for those residents with urinary incontinence concerns.	8/2/14	

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F 315	<p>Continued From page 32</p> <p>Minimum Data Set (MDS) assessment revealed she was not on a current toileting program and was occasionally incontinent.</p> <p>Interview on 6/25/14 at 5:00 p.m. with the social services designee, administrator, and the director of nursing (DON) regarding resident 6 revealed: *She was independent in all care areas except for being occasionally incontinent. *They had not considered her for assisted living because of her being occasionally incontinent. *They had not evaluated or assessed her for a toileting program since her admission on 12/27/13.</p> <p>Review of resident 6's 6/11/14 care plan revealed a goal that stated "to be continent of bowel and bladder and remain independent in toileting tasks see ADL [activities of daily living] flow sheets." An approach that stated "if incontinent document in ADL flow sheets." There were no other approaches that had addressed being incontinent.</p> <p>2. Review of resident 1's 5/9/14 quarterly MDS assessment revealed she was on a current toileting program and was frequently incontinent.</p> <p>Review of resident 2's 5/15/14 quarterly MDS assessment revealed she was on a current toileting program and was frequently incontinent.</p> <p>Review of resident 3's 5/29/14 annual MDS assessment revealed she was on a current toileting program and was frequently incontinent.</p> <p>Review of resident 8's 6/12/14 significant change MDS assessment revealed she was on a current toileting program and was frequently incontinent.</p>	F 315	<p>The Administrator and Director of Nursing reviewed and revised the policies and procedures of urinary incontinence and the toileting program to ensure appropriate evaluation and assessments are completed and individualization of the toileting programs to help restore as much normal bladder function as possible for residents with urinary incontinence concerns.</p> <p>The Director of Nursing or designee will audit all residents with frequent urinary incontinence concerns twice a month for three months to ensure appropriate evaluation and assessments are completed and individualization of the toileting programs to help restore as much normal bladder function as possible for those residents.</p> <p>The Director of Nursing or designee will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.</p>		

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F 315	Continued From page 33 No assessments had been completed on any of the above residents. Review of the toileting program documentation book revealed all residents on a toileting program had a schedule of "upon rising, before and after meals, upon retiring to bed, and PRN [as needed]. Residents will be checked for incontinence and changed as needed every 2-3 hours during the night and PRN." Interview on 6/25/14 at 5:15 p.m. with the DON regarding the provider's toileting program revealed: *They had no current method of evaluating or assessing the residents to determine the need for a toileting program. *The toileting program had not been individualized. Review of the provider's April 2014 Toileting Plan for Urinary Incontinence policy revealed: **Clinical judgment will be used by staff to determine resident's ability to participate in a toileting schedule." ***Residents will be reevaluated whenever there is a change in their status or by the Interdisciplinary team." ***Resident will be assessed for appropriateness of toileting plan being considered." ***Toileting programs will start with a 3 to 5 day toileting trial for new admissions or for a new resident being considered to utilize a toileting plan to help assess resident's need for toileting plan."	F 315	* A bowel and bladder assessment was done on Resident 1 during the week of 7/13/14. Resident 1 will remain on a toileting program with a goal set-up according to the assessment findings. JK/SDDOH/MF * A bowel and bladder assessment was done on Resident 2 during the week of 7/20/14. Resident 2 was removed from the toileting program due to memory issues. JK/SDDOH/MF * A bowel and bladder assessment was done on Resident 3 during the week of 7/20/14. Resident 3 was placed on a toileting plan specific to the results of the assessment. JK/SDDOH/MF	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	<p>Continued From page 34</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, and policy review, the provider failed to provide correct identification and safe storage of a chemical disinfectant in three of three bathing rooms. Findings include:</p> <p>1. Observation on 6/23/14 from 4:10 p.m. to 4:40 p.m. in the unlocked bathing rooms on the 100 and 300 wings revealed large, white, covered, opaque, plastic, round, containers with the original labels which identified the contents as laundry detergent. Those containers were one quarter full of a pale gold fluid, and left next to the toilet in each of the the bathing rooms, both of which were unlocked.</p> <p>Interview on 6/25/14 at 8:28 a.m. with certified nursing assistant E and housekeeper F revealed the large, round containers in the bathing rooms labeled laundry detergent was the disinfectant called ph7Q made by Betco. It was used to clean the floors.</p> <p>Review of the provider's undated Housekeeping and Maintenance Department Responsibilities policy revealed "Never put a chemical in a bottle that is not correctly labeled."</p>	F 323	<p>The bathing rooms on the 100, 200, and 300 wings were observed to ensure that these environments remained free of accident hazards as is possible and that chemicals were correctly identified and safely stored.</p> <p>All other resident areas were observed to ensure that these environments remained free of accident hazards as is possible and that chemicals are correctly identified and safely stored.</p> <p>The Administrator and Maintenance Director reviewed and revised the policies of chemical storage to ensure that that chemicals are correctly identified and safely stored.</p> <p>The Maintenance Director or designee will audit the facility once per month for three months to ensure that the environment remains free of accident hazards as is possible and that chemicals are correctly identified and safely stored.</p> <p>The Maintenance Director or designee will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.</p>	8/2/14	

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F 323	Continued From page 35 Review of manufacturer's material safety data sheet for this disinfectant, dated 9/25/12, revealed the disinfectant: *Should have been stored in the original container. *Was corrosive (damaging to whatever it comes in contact with). *Was harmful if swallowed. *Could have caused severe irritation to skin. *Could have been severely irritating to eyes, with a risk of serious damage possible.	F 323	*on 6/25/14 all of the 5 gallon buckets labels were replaced with correct ones, and were placed in a locked closet across from the bathing room. JKSDDOH/MF *All staff education occurred on 7/24/14. JKSDDOH/MF *Auditing for chemical security will be on-going monthly by the maintenance director or designee & reviewed at the QAPI meeting. JKSDDOH/MF	
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on interview, record review, and policy review, the provider failed to ensure physician's progress notes and physician's orders were signed by the physician in a timely manner for 2 of 15 sampled residents (4 and 7). Findings include: 1. Review of resident 4's complete medical record revealed the progress notes from 2/5/14 and	F 386	Resident 4 and 7's physician's orders were reviewed to ensure that the physician had reviewed the resident's total program of care, including medications and treatments, at each visit and had written, signed, and dated progress notes at each visit as well as signed and dated all orders with the exception of pneumococcal polysaccharide and influenza vaccines. All other residents' physician orders were reviewed to ensure that the physician had reviewed the resident's total program of care, including medications and treatments, at each visit and had written, signed, and dated progress notes at each visit as well as signed and dated all orders with the exception of pneumococcal polysaccharide and influenza vaccines.	8/2/14

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F 386	<p>Continued From page 36 4/2/14 were not signed by the physician.</p> <p>2. Review of resident 7's complete medical record revealed: *The provider's routine admission orders dated 5/23/14 and signed by the physician ordered a full code (would do cardiopulmonary resuscitation [CPR] and be kept alive by artificial life support) for the resident. *The advance directives form, signed by the resident, requested the resident not be resuscitated (would not do CPR and not be kept alive by artificial life support). was faxed to the physician on 5/27/14. -There was no copy of that form with the physician's signature. *The physician's summary order sheet dated 6/19/14 had not included an order for do not resuscitate.</p> <p>3. Interview on 6/25/14 at 3:00 p.m. with the director of nursing revealed: *Her expectation was for the physician to have signed the physician's progress notes and orders. *She was unable to locate a policy that covered the signing of physician's progress notes.</p> <p>Review of the provider's 3/17/14 Self Determination and No Cardiopulmonary Resuscitation Requests (CPR) policy revealed: *CPR would be attempted for all residents unless there was a "NO CODE" order written by the physician on the physician's order sheet and documentation from the resident, family, or responsible party of the request. *If the resident informed the provider in writing of a request for no CPR or artificial life support the provider would contact the attending physician and inform him of the request.</p>	F 386	<p>The Administrator and Director of Nursing reviewed and revised the policies and procedures of physician services and physician orders to ensure that they include revision of resident's total program of care, including medications and treatments at each visit as well as written, signed, and dated orders in a timely manner.</p> <p>The Director of Nursing or designee will audit all residents' new physician orders twice a month for two months and once a month for one more month to ensure that the physician had reviewed the resident's total program of care, including medications and treatments, at each visit and had written, signed, and dated progress notes at each visit as well as signed and dated all orders.</p> <p>The Director of Nursing or designee will present the findings of the audit at the monthly QAPI meetings with further follow up as recommended by the committee.</p> <p><i>*Education was provided to the nursing department on 7/29/14. JKJDDOHI MF</i></p>		

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F 386	Continued From page 37 *The attending physician would have then given a written order to comply with the resident's request. *The provider would then comply with the resident's request.	F 386	<i>* Auditing of the physician orders will be on-going monthly by the DON or designee. JK/SDBOH/ME</i>	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	The infection control program was reviewed to ensure appropriate audits were being completed so that there is a means to investigate, control, and prevent infections in the facility. The Infection Control Nurse, Director of Nursing, and the Administrator reviewed and revised the infection control policies to ensure that appropriate audits are being completed so that there is a means to investigate, control, and prevent infections in the facility. Education will be provided to all staff on the revised policies and procedures as well as any pertinent steps necessary to investigate control and prevent infections in the facility. The Infection Control Nurse or designee will create and conduct appropriate audits twice a month for three months to ensure that appropriate audits are being completed so that there is a means to investigate, control, and prevent infections in the facility.	8/2/14

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NAME OF PROVIDER OR SUPPLIER AURORA-BRULE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383	
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F 441	<p>Continued From page 38</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 A. Based on interview and record review, the provider failed to audit the effectiveness of one of one infection control programs. Findings include:</p> <p>1. Interview on 6/25/14 at 10:50 a.m. with the infection control nurse revealed: *There were no audits on the effectiveness of infection control training following the orientation of staff during the last five months. *There were no audits concerning the infection control program during the last five months. *There had been no audits concerning the infection control program brought to the quality assurance program improvement (QAPI) meetings for the last five months.</p> <p>Interview on 6/25/14 at 3:00 p.m. with the director of nursing (DON) revealed: *She had no audits on the infection control program. *She expected the audits to be completed by the infection control nurse.</p> <p>Review of the provider's plan of correction regarding the January 2014 survey revealed: *The director of nursing, infection control nurse, or designee would: -Audit the infection control program once a week for one month, then audit monthly for an</p>	F 441	<p>The Infection Control Nurse or designee will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.</p> <p>Residents 11, 12, and 13's eye medication administration was observed and 11's blood glucose check was observed to ensure that those processes were conducted in a safe, sanitary, and comfortable environment for the resident as to prevent the development and transmission of disease and infection.</p> <p>All other resident eye medication administration and blood glucose checks were observed to ensure that those procedures were conducted in a safe, sanitary, and comfortable environment for the resident as to prevent the development and transmission of disease and infection.</p> <p>The Administrator, Director of Nursing, and Infection Control Nurse reviewed the policies and procedures for proper eye medication administration and blood glucose checks to ensure that those procedures were conducted in a safe, sanitary, and comfortable environment for the resident as to prevent the development and transmission of disease and infection.</p>	

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F 441	<p>Continued From page 39 additional two months. *The DON, infection control nurse, or designee would present the findings of the audits at the monthly QAPI meetings with further follow-up as recommended by the committee. *Following a phone revisit the facility had been placed back in compliance on 3/11/14.</p> <p>Surveyor: 32355 B. Based on observation, interview, and policy review, the provider failed to ensure the potential for cross-contamination had not occurred for: *Three of three randomly observed residents (11, 12, and 13) who required assistance with eye medication administration. *One of two randomly observed residents (11) who had the diagnosis of diabetes (unable to control sugar levels in the blood) and required routine blood sugar monitoring. Findings include:</p> <p>1. Observation on 6/24/14 at 7:50 a.m. of registered nurse (RN) A revealed: *She prepared to administer eye medication to resident 11. *She had retrieved a container with the bottle of eye medication from inside the medication cart. *She entered the resident's room and placed the container directly on top of the resident's counter by the sink. No barrier had been placed between the container and the counter top. *She washed her hands, retrieved the container, and removed the bottle of eye medication from inside the container. *She administered the eye medication to the resident and returned the container back inside the medication cart.</p>	F 441	<p>The Infection Control Nurse or designee will audit the administration of all residents with eye medication and blood glucose checks twice a month for three months to ensure that those procedures were conducted in a safe, sanitary, and comfortable environment for the resident as to prevent the development and transmission of disease and infection.</p> <p>The Infection Control Nurse or designee will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.</p> <p><i>*Education was provided to the nursing department on 7/29/14 JKISDDHMF</i></p> <p><i>*The infection control nurse will be auditing hand washing, isolation procedures, laundry and the handling of the linens, infections, oxygen concentrators, catheter cares, eye drop administration, and blood glucose. The infection control nurse is currently setting up a schedule to do (continued p 41)</i></p>		

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F 441	<p>Continued From page 40</p> <p>Observation on 6/24/14 at 10:15 a.m. of RN A revealed:</p> <ul style="list-style-type: none"> *She prepared to administer eye medications to residents (12 and 13). *She had retrieved three containers from the medication cart that had contained the eye medications. *She entered resident 12's room and placed all three of the containers directly on the counter top by the sink. No barrier had been placed between the containers and the counter top. *She washed her hands, retrieved one of the containers, and removed the bottle of eye medication from inside the container. *She administered the eye medication to resident 12 and placed the container with the eye medication inside of her shirt pocket. *She entered resident 13's room and repeated the same routine as observed above. *After she had completed the eye medication administration to residents 12 and 13 she placed all three of the containers back inside of the medication cart. <p>2. Observation on 6/24/14 at 7:52 a.m. of RN A revealed:</p> <ul style="list-style-type: none"> *She prepared to do a blood glucose check (test to check sugar levels in the blood) for resident 11. *She retrieved a large plastic container from inside of the medication cart. *She entered the resident's room and placed the plastic container on her bed. No barrier had been placed between the container and the bed. *She checked resident 11's blood sugar level, retrieved the plastic container, and had returned it to the inside of the medication cart. <p>3. Interview on 6/24/14 at 3:15 p.m. with the DON regarding all of the above observations confirmed</p>	F 441	<p><i>these audits randomly on a monthly basis according to necessity and priority.</i></p> <p><i>JK/SDD/HMF</i></p>		

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F 441	Continued From page 41 the potential for cross-contamination had occurred. A barrier should have been placed underneath the items taken into the residents' rooms. Review of the provider's March 2014 Policy and Procedure for Obtaining a Fingerstick Glucose Level revealed a kleenex or paper towel were to have been placed on the resident's bedside stand with the supplies placed on top. Review of the provider's 11/8/12 Medication Administration for Ophthalmic Drops policy revealed no process for set-up in the resident's room.	F 441			

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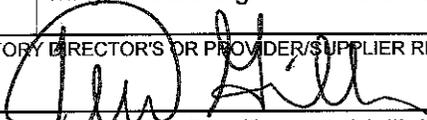
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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/25/14. Aurora-Brule Nursing Home was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K047, K062, and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state law. Without waiving the foregoing statement, the facility states that with respect to: The chapel exit, the east corridor exit, and the south exit of Flair wing were observed to ensure that exit and directional signs are displayed with continuous illumination also served by the emergency lighting system. All other exits were observed to ensure that the exits and directional signs are displayed with continuous illumination also served by the emergency lighting system. The Maintenance Director replaced the lighting in the exit signs for the chapel exit, the east corridor exit, and the south exit of Flair wing to ensure that there was continuous illumination that is also served by the emergency lighting system. The Maintenance Director or designee will audit all exit doors twice a month for three months to ensure that the exit signs are displayed with continuous illumination.	8/2/14
K 047 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to provide exit signs with continuous illumination in three randomly observed exit signs (chapel, east corridor, and south exit of Flair wing). Findings include: 1. Observation beginning at 10:00 a.m. on 6/25/14 revealed the following exit signs had lamps burned out: exit sign from the chapel, exit sign near the cross-corridor doors into the Flair wing, and exit sign from the south exit from the	K 047		

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

TITLE

(X6) DATE



Administrator 7-24-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 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 7 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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If continuation sheet Page 1 of 3
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K 047	Continued From page 1 Flair wing. Interview with the maintenance supervisor at the time of the observations confirmed those conditions.	K 047	The Maintenance Director will present the findings of the audit at the monthly QAPI meetings with further follow up as recommended by the committee.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on record review and interview, the provider failed to ensure the automatic sprinkler system was continuously maintained in reliable operating condition and inspected and tested periodically in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Findings include: 1. Review of the provider's automatic sprinkler system annual inspection report dated 6/3/14 revealed no documentation for when the last five year internal obstruction investigation had been conducted. Interview with the maintenance supervisor and administrator at the time of the exit interview indicated they were unaware of the five year internal obstruction investigation testing requirements.	K 062	The automatic sprinkler system was observed to ensure that a five year internal obstruction investigation had been completed as to keep the system in reliable, operating condition. Midwestern Mechanical was called out to the facility to complete the five year internal obstruction investigation so that the system is kept in reliable, operating condition. The Maintenance Director or designee will audit the automatic sprinkler system's five year internal obstruction investigation once a month for three months to ensure the system is kept in reliable, operating condition. The Maintenance Director or designee will present the findings of the audit at the monthly QAPI meetings with further follow up as recommended by the committee.	8/2/14
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	The generator was observed to ensure that weekly testing and monthly exercises under load for 30 minutes per month were completed.	8/2/14

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K 144	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on document review and interview, the provider failed to conduct operational inspection and testing for one of one emergency generator per National Fire Protection Association (NFPA) 110. Findings include: 1. Document review at 10:00 a.m. on 6/25/14 revealed no record of the required routine maintenance and operational testing of the generator. Interview with the maintenance supervisor revealed he was not aware of the required maintenance and testing of the generator. Further interview revealed the maintenance supervisor was new to the job and he was still learning all the requirements. The maintenance supervisor was provided documentation indicating some of the routine maintenance and operational testing requirements. Further advice was provided to have a professional service company hired to provide further knowledge of the facility's emergency power source.	K 144	The Administrator and Maintenance Director reviewed and revised the policies of the generator so that they included weekly testing and monthly exercises under load for 30 minutes. The Maintenance Director will audit the weekly and monthly testing of the generator once a week for two months to ensure that weekly testing and monthly exercises under load for 30 minutes are being completed. The Maintenance Director will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.	