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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435129 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/14/2015 |
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| NAME OF PROVIDER OR SUPPLIER DELLS NURSING AND REHAB CENTER INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 THRESHER DR DELL RAPIDS, SD 57022 |
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| F 000 | <p><i>Addendums noted with an asterisk per 8/12/15 telephone to facility Administrator and DON.</i></p> <p>Surveyor: 32335 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/7/15 through 7/9/15 and 7/13/15 through 7/14/15. Dells Nursing and Rehab Center Inc. was found not in compliance with the following requirements: F156, F157, F159, F166, F222, F224, F226, F241, F248, F250, F253, F280, F281, F283, F309, F311, F314, F315, F323, F329, F371, F425, F441, F456, F493, F501, and F520.</p> | F 000 | F000 | |
| F 156 SS=D | <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and</p> | F 156 | F156 | 8/12/2015 |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> | TITLE ADMINISTRATOR | (X6) DATE 8/7/2015 |
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 156 | <p>Continued From page 1</p> <p>the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and</p> | F 156 <i>two</i> <i>OWLS000H/JJ</i> <i>Weekly</i> <i>OWLS000H/JJ</i> | <p>Social Services Director or designee will perform audits on appropriate notification of changes in services and charges for 4 weeks and monthly for two more months <i>or until directed otherwise by the QAPI Committee.</i></p> <p>Social Services Director or designee will present the audit findings at the monthly QAPI meetings for review.</p> | <i>OWLS000H/JJ</i> |
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| F 156 | <p>Continued From page 2</p> <p>misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on interview and record review, the provider failed to make available at least a two days notice to inform the resident or authorized representative of the end of Medicare coverage for skilled therapy services for one of three sampled residents (19). Findings include:</p> <p>1. Review of resident 19's denial notice revealed: *Coverage for skilled therapy was to have ended on 5/22/15. *Notice of Medicare Non-Coverage form was signed by the authorized representative on 5/21/15, one day before coverage ended.</p> <p>Interview on 7/13/15 at 11:35 a.m. with the social worker regarding denial notices revealed she: *Was aware they were to provide at least a two day notice when coverage was scheduled to end.</p> | F 156 | | |
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| F 156 | Continued From page 3 *Believed the authorized representative of resident 19 was aware of the ending of services before the date she signed the Notice of Medicare Non-Coverage form. *Made no documentation the authorized representative of resident 19 was aware of the services ending before 5/21/15. *Was not aware of any policy or procedure regarding the above process. Interview on 7/14/15 at 8:40 a.m. with the administrator revealed he agreed there should have been at least a two day notice the Medicare coverage was ending for resident 19. | F 156 | | | |
| F 157 SS=E | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a | F 157 | F157 Respective physicians for residents 1 & 5 were notified on 8/5/2015 regarding change of condition that was not reported in a timely manner. Residents 14 & 15 are no longer in the facility. Physicians of all other residents will be notified immediately who have a change of condition or order not being completed. Administrator, DON, governing board, social services, and interdisciplinary team reviewed and revised as necessary the policies and procedures about resident rights as they pertain to appropriate resident, family, and physician notification of change in condition. | 8/12/2015 | |

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| F 157 | <p>Continued From page 4</p> <p>change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, closed record review, interview, and policy review, the provider failed to ensure the physicians were notified of changes in condition for four of four sampled residents (1, 5, 14, and 15). Findings include:</p> <p>1. Review of resident 5's medical record revealed: *A 6/13/13 admission date. *Diagnosis of Alzheimer's disease.</p> <p>Review of resident 5's 6/23/15 at 8:00 p.m. through 6/24/15 at 10:15 a.m. nursing progress notes revealed: *8:00 p.m.-"Resident was found laying on his stomach on the floor next to the nurse station. It appeared that the resident had been sleeping in his wheelchair and fell forward onto the floor." **"He has a half centimeter [cm] laceration [cut] above left eyebrow on forehead that is fairly superficial. Also a laceration on the bridge of his nose that is approximately 0.25 cm also superficial. Both had minimal bleeding." ***"His nose appears to be broke, but did not have epistaxis [nosebleed]."</p> | F 157 | <p>DON or designee will provide education on 8/10/2015 for facility staff regarding resident rights as they pertain to appropriate resident, family, and physician notification of change in condition. All new employees will be provided education with orientation process.</p> <p>DON or designee will perform audits on two resident charts to ensure appropriate resident, family, and physician notification of change in condition for 4 weeks and monthly for two more months or until directed otherwise by the QAPI committee. <i>pwlsd00H/JJ</i></p> <p>DON or designee will present the audit findings at the monthly QAPI meetings for review.</p> | |
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| F 157 | <p>Continued From page 5</p> <p>**Also has an abrasion [scrape] to his left knee and on his left hand middle finger, a start of bruising and he is able to move his finger but it is painful. There is a small amount of swelling to his hand by the knuckles of his middle finger."</p> <p>**He had no other complaints of pain or discomfort, except for pain from his finger and general discomfort that he says is normal."</p> <p>**Will continue to monitor for worsening and for additional injury."</p> <p>**Son notified."</p> <p>*3:11 a.m.- "Resident complains pain from his middle finger and hand on his left related to fall last night. He also complains of general discomfort which he says is usual for him and not related to the fall."</p> <p>*9:50 a.m.- "Left facility to be seen by doctor related to injuries from fall on 6/23/15. Increased pain and edema [swelling] noted to left hand. Nose enlarged. Transported by facility van."</p> <p>*10:15 a.m.- "Returned from appointment with doctor. He instructed resident to use ice to hand and face and also use Tylenol for pain. No fractures to left hand."</p> <p>Interview on 7/14/15 at 10:00 a.m. with the director of nursing (DON) regarding resident 5 revealed:</p> <p>*The physician had not been contacted regarding his fall with injury until he was seen by him on 6/24/15 at 9:50 a.m.</p> <p>*Since the nurse thought his nose was broken, and he had pain and swelling in his left hand on 6/23/15 after the fall, the physician should have been contacted at that time.</p> <p>2. Review of resident 14's medical record revealed:</p> <p>*A 7/3/13 admission date.</p> | F 157 | | | |

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| F 157 | <p>Continued From page 6</p> <p>*Diagnoses: chronic airway obstruction (difficulty breathing), chronic kidney disease, and history of deep vein thrombosis (DVT) (blood clots in the legs that cause swelling or pain but may occur without symptoms.)</p> <p>*She had been hospitalized from 5/27/15 to 5/30/15 for pneumonia (lung infection), gastritis (stomach inflammation), and clostridium difficile (bacteria in the intestines that causes diarrhea [loose stools]).</p> <p>*She was alert and oriented (memory okay).</p> <p>*She told the nursing staff on 6/14/15 she thought she had a blood clot in her left leg.</p> <p>*She frequently complained of pain in her left leg from 6/14/15 until she was sent to the hospital on 6/18/15 for a peripheral central catheter (catheter inserted into an arm vein that goes directly into the heart) insertion.</p> <p>*There was no documentation the physician had been informed of her concern she had a blood clot or her increased pain and swelling in the left leg.</p> <p>Interview on 7/14/15 at 10:00 a.m. with the DON regarding resident 14 revealed:</p> <p>*The physician should have been called on 6/14/15 when the resident told the nurse she had a blood clot in her leg.</p> <p>*The resident was alert, but she would often tell the nursing staff one thing and tell her daughter something else.</p> <p>*An increase in edema in the left leg on 6/16/15 also should have been reported to the physician, and her continued complaints of pain in the leg. The Tramadol had been effective to control her pain when she would accept it from the nursing staff.</p> <p>Refer to F309, finding 1.</p> | F 157 | | |

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| F 157 | <p>Continued From page 7</p> <p>Surveyor: 32335</p> <p>3. Review of resident 1's medical record revealed he had entered the facility on 6/13/14 with one stage two pressure ulcer (a sore caused by unrelieved pressure that resulted in damage to skin) on his right coccyx (tailbone area). It had taken three months to heal. The treatment had not changed during those three months. From 6/13/14 through 7/13/15 he had developed seven pressure ulcers on his bottom. There was no documentation the physician had been notified of when the pressure ulcers had developed, the effectiveness of the treatment being used, and when they had healed. Refer to F314, finding 2.</p> <p>Surveyor: 35625</p> <p>4. Review of the closed record for resident 15's 5/11/15 physician's order revealed an order to discharge her home with home health services and medications.</p> <p>Interview on 7/9/15 at 10:25 a.m. with the social worker regarding resident 15 revealed: *Her daughter was given information regarding home health services. The daughter stated she would make her own referral if necessary, as she had been considering hospice (terminal) care instead. *She had notified the physician the family did not want home health services and was considering hospice services. *She should have informed the physician the discharge orders for home health services was not done due to family request.</p> <p>Interview on 7/9/15 at 11:40 a.m. with the DON regarding resident 15 revealed: *They had not sent any medications home with</p> | F 157 | | | |

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| F 157 | Continued From page 8 her as ordered by the physician due to her payment source. *The medications had been sent back to the pharmacy. *The physician should have been notified they had not sent her medications home with her. Review of the provider's undated Physician Orders/Telephone Orders policy revealed any corrections and deletions from present orders required a physician's order. | F 157 | | | |
| F 159 SS=E | 483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's | F 159 | F159 All residents bearing a resident trust fund account were reviewed to ensure money was kept in an interest bearing account, the recommended amounts were available, and the money was secured from possible loss. Administrator, DON, governing board, social services, and interdisciplinary team <i>created</i> <i>dw15000H/JJ</i> the policies and procedures about resident rights as they pertain to facility management of resident personal funds. <i>*the facility admission packet was updated as well. dw15000H/JJ</i> Social Service Director will provide education on 8/10/2015 for facility staff regarding resident rights as they pertain to facility management of resident personal funds. All new employees will be provided education with orientation process. | 8/12/2015 | |

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| F 159 | <p>Continued From page 9 behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on record review and interview, the provider failed to manage the residents' trust fund account to ensure: *Money was kept in an interest bearing account. *Recommended amounts were available. *Secured from possible loss. Findings include: 1. Interview and review of the residents' trust fund documents on 7/13/15 at 11:35 a.m. with the social worker revealed: *She was the person assigned to handle the residents' trust fund account. *The residents' funds were held within the building and were not in an interest bearing</p> | F 159 | <p>Social Services Director or designee will perform audits on five select residents ^{weekly} bearing a resident trust fund account ^{DJ/SAWH/JJ} for 4 weeks and monthly for two more months ^{or} until directed otherwise by the QAPI committee. Social Services Director or designee will ^{DJ/SAWH/JJ} present the audit findings at the monthly QAPI meetings for review.</p> | |
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| F 159 | <p>Continued From page 10</p> <p>account in a local financial institution.</p> <p>*The residents were limited to keeping \$50 in their resident trust fund.</p> <p>-If a resident went over the \$50 they or their family/authorized representative were encouraged to remove the amount over \$50.</p> <p>*The resident trust account listing dated 7/8/15 revealed:</p> <p>-Forty-one residents had funds in the account.</p> <p>-Three residents were presently over the \$50 limit.</p> <p>-Ten residents had exactly \$50 in their account.</p> <p>*All of the funds were kept in a locked cupboard in the medication room.</p> <p>-All nurses had keys to the medication room.</p> <p>-One nurse each shift had a key to the cupboard that contained the trust fund money.</p> <p>*The entire amount of the trust fund was contained in an expandable folder with each of the resident's funds in a separate envelope in the folder.</p> <p>*Funds were counted once a month by the social worker.</p> <p>-Deposit and withdrawal slips or notes were left for the social worker to balance the accounts.</p> <p>*All but one resident could access their funds at any time.</p> <p>-That resident was prevented from accessing funds, because she would spend it all.</p> <p>-That resident's envelope with funds was kept in the social worker's office.</p> <p>*The process had previously involved index cards used as ledger cards to track the amount.</p> <p>*There were no policies or procedures regarding the resident trust fund. However there was information in the admission packet for the resident.</p> <p>2. On 7/13/15 at 4:44 p.m. an audit of the trust</p> | F 159 | | | |

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| F 159 | <p>Continued From page 11</p> <p>fund account with the social worker revealed two residents' envelopes with amounts that were not easily reconciled as to what should have been in the account. One was plus \$30.21, and the other was short five cents.</p> <p>Review of the provider's undated admission packet information revealed: *In the informational manual under personal funds it stated: -"We ask that no money be left in a resident's room. Rather, the resident has three options for maintaining their money within the nursing home 1. Up to \$50 may be given to the Social Worker who is responsible for maintaining personal accounts. 2. Funds will be locked up by the charge nurse. A resident may ask at anytime for money from this location. When money is deposited or withdrawn from the resident's envelope, the resident will be given a receipt and will sign ledger card." -There was no third option listed. *In the informational manual under Valuable Policy it stated: -"A resident may continue to handle their own finances. They are able to place up to \$50 in a non-interest bearing account with the social worker. The resident can withdraw money from this account as the need may arise (i.e. [that is] outings with family and friends). A quarterly statement will be sent out to the resident." *In the admission agreement, under authorization it stated: "Resident Personal Trust Fund" - "I do, do not authorize the facility to handle personal funds. The Resident may not hold more than \$50 in fund and will not receive interest for these funds."</p> <p>Interview on 7/14/15 at 8:40 a.m. with the</p> | F 159 | | | |

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| F 159 | Continued From page 12 administrator revealed: *He knew the residents' funds were not in an interest bearing account in a local financial institution. *The \$50 limit was in place when he came, and he had not questioned why the limit was in place or the amount. *He had known the funds were all locked in the medication room. *He had not realized one resident's funds were being handled differently than the other residents' funds. Interview on 7/14/15 at 10:20 a.m. with the director of nursing revealed she had not been aware that the entire trust fund account was locked in the medication room. She thought there was only some petty cash locked in the medication room. | F 159 | | | |
| F 166 SS=D | 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to resolve grievances (complaints) addressed in resident council and individual grievances brought to staff attention. Findings include: 1. Review of resident council minutes from | F 166 | F166 The last 6 months of resident council minutes were reviewed to ensure grievances were resolved. Administrator, DON, governing board, social services, and interdisciplinary team reviewed and revised as necessary the policies and procedures about resident rights as they pertain to appropriate response to grievances. | 8/12/2015 | |

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| F 166 | Continued From page 13 1/20/15 through 6/16/15 revealed: *On 1/20/15 a resolved concern had been "staff that are helping in the dining room need to have their hair tied up. Council stated that they see it has been addressed because it is much better." -There had been no explanation of what had occurred to resolve the issue. *On 4/14/15 the concerns listed had been: -"At the evening meal, council stated they need more help passing the food and coffee. The wait time is too long and sometimes they are not getting coffee and the food is cold. -Staff needs to remember to please wear your nametags and walkie talkie. -Staff needs to remember to keep nails short as they scratch the residents. -Council stated they would like to see Management staff here on the weekends. Council feels that they are busy times. It would help out with answering phones, etc." *On 5/12/15 a new concern had been "the temperatures in the dining room are dramatically changing from day to day." *On 5/12/15 pending concerns had been "Council stated they would like to see Management staff here on the weekends. Council feels that they are busy times. It would help out with answering phones, etc." *On 5/12/15 Resolved concerns had been: -"At the evening meal, council stated they need more help passing the food and coffee. The wait time is too long and sometimes they are not getting coffee and the food is cold. -Staff needs to remember to please wear your nametags and walkie talkie. -Staff needs to remember to keep nails short as they scratch the residents." *There had been no explanation as to why the one concern was still pending and how the others | F 166 | Activity Director or designee will provide education on 8/10/2015 for facility staff regarding resident rights as they pertain to appropriate response to grievances. All new activity employees will be provided education with orientation process. Activity Director or designee will perform audits on resident council grievances to ensure they receive proper response and follow up for 4 weeks and monthly for two more months <i>or until directed otherwise by the QAPI Committee. DW/SAH/TJ</i> Activity Director or designee will present the audit findings at the monthly QAPI meetings for review. | | |

*weekly
DW/SAH/TJ*

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| F 166 | <p>Continued From page 14</p> <p>had been resolved.</p> <p>*On 6/16/15 the pending concern had been "the temperatures in the dining room are dramatically changing from day to day."</p> <p>*On 6/16/15 the resolved concern had been "Council stated they would like to see Management staff here on the weekends. Council feels that they are busy times. It would help out with answering phones, etc."</p> <p>*There had been no explanation as to why the one concern was still pending and how the others had been resolved.</p> <p>Confidential group interview on 7/7/15 at 4:00 p.m. with ten residents revealed:</p> <p>*They felt they were not told when concerns were resolved.</p> <p>*They did not tell staff things because "nothing ever gets done."</p> <p>*They felt the concern about staff tying their hair back had not been resolved.</p> <p>-They felt it was still happening.</p> <p>-One resident had found hair in her food.</p> <p>*Some residents who wanted to remain anonymous had spoken to the director of nursing (DON) regarding certified nursing assistant (CNA) I being rude to residents.</p> <p>-They had not been talked to regarding if that had been looked into.</p> <p>Interview on 7/9/15 at 10:00 a.m. with the DON regarding CNA I revealed:</p> <p>*One resident had reported CNA I had embarrassed her, was abrupt, and rushed during care.</p> <p>*The DON had spoken to CNA I and gave her a verbal warning to "slow down and reminded her to talk quietly to maintain resident's privacy."</p> <p>*She had not addressed what was said to the</p> | F 166 | | |

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| F 166 | <p>Continued From page 15</p> <p>resident or that she had embarrassed her, only how loud she had been.</p> <p>*She had not conducted any other interviews and had not investigated the situation for abuse or neglect.</p> <p>*She had not followed-up with the resident but had the social worker talk to her.</p> <p>Interview on 7/14/15 at 8:30 a.m. with the activity coordinator revealed:</p> <p>*She usually would take concerns from resident council to the department heads.</p> <p>*She had not documented when issues were taken to the department heads.</p> <p>*She usually determined if something was resolved by asking the resident council members.</p> <p>*There was no documentation on when she asked residents about concerns being resolved.</p> <p>*The members were not always consistent.</p> <p>*She had no documented process in place to address grievances.</p> <p>Review of the provider's 5/12/15 Filing Grievances and/or Complaints policy revealed:</p> <p>*Grievances should have been submitted in writing and signed by the resident or the person filing the grievance and/or complaint.</p> <p>*The responsibility of grievance and/or complaint investigation had been delegated to the social services department, DON, and administrator.</p> <p>*Two of the three listed above should have been involved in the investigation.</p> <p>*A written report should have been submitted to the administrator within five days of receiving the grievance and/or complaint.</p> <p>*The administrator should have reviewed the findings to determine the corrective action needed.</p> <p>*The resident or person filing the grievance on</p> | F 166 | | | |

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| F 166 | Continued From page 16 behalf of the resident should have been informed of the findings of the investigation and the actions taken to correct any identified problems. *A written summary of the report should have been provided to the resident or representative. | F 166 | | | |
| F 222 SS=G | 483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Surveyor: 35625 Based on observation, record review, interview, and policy review, the provider failed to ensure one of one sampled resident (2) had not received an antipsychotic medication (alters mood and behavior) for staff convenience of agitation and anxiety. Findings include: 1. Observation on 7/7/15 of resident 2 revealed: *At 11:05 a.m. he was sitting in his wheelchair at a small table in the activity area of the dining room. -He was not doing an activity. -He was faced away from the activity group of residents for greater than ten minutes. -There was no interaction with staff or peers during that time. -He was awake, quiet, and no yelling was observed. *At 11:45 a.m. his wife was assisting him with the | F 222 | F222 Resident 2's care plan was reviewed to ensure antipsychotic medication was not given for staff convenience of agitation and anxiety. All other resident's care plans who receive antipsychotic medications were reviewed to ensure antipsychotic medication was not given for staff convenience of agitation and anxiety. DON, Pharmacist, and Medical Director reviewed and revised as necessary the policy and procedure about appropriate assessment, necessary follow up documentation for use and monitoring for effect. DON or designee will provide education on 8/10/2015 for facility staff regarding utilization and documentation of non-pharmacological interventions including but not limited to pain management, bowel management, and activity interventions for anxiety and agitation. All new employees will be provided education with orientation process. | 8/12/2015 | |

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| F 222 | <p>Continued From page 17 noon meal. -Verbal coaching was used by his wife to encourage him to eat. *At 2:45 p.m. he was in his bed and sleeping.</p> <p>Review of resident 2's complete medical record revealed: *A 12/6/12 admission date. *Diagnoses of glaucoma (increased pressure in eyes), vascular dementia (memory loss), gout (recurrent attacks of arthritis), hypertension (high blood pressure), legal blindness, macular degeneration (impaired vision), history of vertigo (dizziness), history of heel ulcers (sores).</p> <p>Review of resident 2's 9/17/13 through 10/4/13 behavioral health hospitalization notes revealed: *Haldol (a mood and behavior altering medication) 5 milligrams (mg) as needed twice daily was initiated for agitation/anxiety/behavioral changes. * A diagnosis of vascular dementia and delirium (acute confusion) NOS (not otherwise specified)-pain related. *The provider made a recommendation to consider treating pain, as agitation might have been the resident's method for expressing pain. *Follow-up medication management was to be completed by the resident's primary care physician.</p> <p>Review of resident 2's 6/19/14 pharmacy consultation note revealed: *The resident had been prescribed Haldol 5 mg twice daily as needed. *He had only been using the medication a "handful" of times each month. *A recommendation was made to treat anxiety with as needed (PRN) lorazepam (a medication</p> | F 222 | <p>DON or designee will perform audits on ^{*two} select residents with antipsychotic medications to ensure they were not received for staff ^{*weekly} convenience of agitation and anxiety for 4 ^{*weekly} weeks and monthly for eleven more months.</p> <p>DON or designee will present the audit findings at the monthly QAPI meetings for review.</p> | <p><i>Dw/500H/JJ</i></p> <p><i>Dw/500H/JJ</i></p> | |

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| F 222 | <p>Continued From page 18 to reduce anxiety).</p> <p>Review of resident 2's 6/26/14 through 7/25/14 nursing progress notes revealed: *A physician's order had been obtained to discontinue the PRN Haldol and change the medication to lorazepam 0.5 mg every six hours PRN per pharmacy recommendations. *The lorazepam was administered fourteen times for the resident yelling or showing unspecified signs of anxiety. -The follow-up results of twelve of the lorazepam doses were documented as "effective." -Two doses of the lorazepam were documented "ineffective." One of the ineffective doses had "music was helpful." *On 7/20/14 at 10:21 p.m. "Placed call to on-call physician related to PRN Ativan [lorazepam] not being effective. Informed that a fax had been sent to his office asking to change the PRN Ativan [lorazepam] back to PRN Haldol."</p> <p>Review of resident 2's 7/24/14 physician's order revealed: *Lorazepam PRN was to be discontinued. *Haldol 5 mg twice daily as needed for agitation/anxiety. **"Ativan [lorazepam] was tried and found to be less effective."</p> <p>Review of resident 2's 3/10/15 consultant pharmacist communication revealed: *A recommendation for a gradual dose reduction of Haldol to 2.5 mg twice daily PRN. *The physician agreed, and an order was obtained for Haldol 2.5 mg twice daily PRN.</p> <p>Review of resident 2's 4/1/15 through 7/7/15 medication administration record revealed Haldol</p> | F 222 | | | |

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| F 222 | <p>Continued From page 19</p> <p>was administered:</p> <ul style="list-style-type: none"> *Twelve times from 4/1/15 through 4/30/15. *Eleven times from 5/1/15 through 5/30/15. *Seventeen times from 6/1/15 through 6/30/15. *One time from 7/1/15 through 7/7/15. <p>Review of resident 2's 4/1/15 through 7/7/15 nursing progress notes revealed:</p> <ul style="list-style-type: none"> *There was no documentation of any non-pharmological interventions that had been attempted prior to the administration of the Haldol. *The resident had been treated with antibiotics for a urinary tract infection twice in April and once in June. *Resident had difficulty with bowel movements and required the use of PRN laxatives (medications to promote a bowel movement.) *On 4/19/15 at 2:22 p.m. Haldol was given for the "Resident was yelling for approximately one hour and no quieting down even after redirection x [times] three." -No documentation was made regarding the redirection interventions that were attempted. *On 5/23/15 at 4:41 a.m. Haldol was given without non-pharmological documentation for "Yelling and crawling out of bed." *On 7/7/15 at 9:37 a.m. Haldol was given for "Yelling out." <p>Interview on 7/8/15 at 8:15 a.m. with the director of nursing and the social worker revealed:</p> <ul style="list-style-type: none"> *Haldol was used twice a day as needed (PRN) for agitation/anxiety. *Use of the Haldol had increased over the last three to four months. *There was no documentation the physician had been notified of the increased use of the Haldol. *They had not assessed for pain which was a | F 222 | | |

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| F 222 | Continued From page 20 chronic issue or treated his frequent constipation. *The resident's agitation consisted of yelling out for family members after they had visited him and for farming. *There was no documentation of non-pharmacological interventions that had been attempted when he hollered out. *The nursing staff had discussed administering Haldol around noon. His wife usually came and assisted him daily with his noon meal. *They did not have a policy related to chemical restraint usage. Interview on 7/13/15 at 12:00 noon with the activities director regarding resident 2 revealed there were no interventions put in place for episodes of increased agitation. Review of the provider's 6/3/15 Dignity Policy revealed, "Staff shall treat cognitively impaired [having difficulty with memory, thinking, and reasoning] residents with dignity and sensitivity; for example, addressing the underlying motives for root causes for behavior; and not challenging or contraindicating the resident's beliefs or statements." Refer to F248, finding 1. | F 222 | | | |
| F 224 SS=G | 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. | F 224 | F224 CNA J was reeducated on 7/17/2015 to follow care plans on resident transfers on Resident 13 and all other residents that require transfer. CNA B & G will be educated on 8/10/2015 regarding proper transfers using a mechanical Hoyer lift for Resident 6, as well as all other residents who require mechanical Hoyer lifts. Resident 14 is no longer in the facility. | 8/12/2015 | |

*and all other direct care staff
awlsdooHBT*

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435129 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/14/2015 |
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| NAME OF PROVIDER OR SUPPLIER DELLS NURSING AND REHAB CENTER INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 THRESHER DR DELL RAPIDS, SD 57022 |
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| F 224 | <p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to ensure neglect had not occurred for: *One of one sampled resident (13) who needed assistance with transferring from one place to another resulting in a major injury. *One of four sampled residents (6) who used a Hoyer lift (equipment to move a resident from one place to another) for transfers resulting in her falling out of the sling. *One of one sampled resident (14) who used her call light to request staff assistance resulting in mental anguish when they refused to get her out of bed. Findings include:</p> <p>1. Review of the undated final report sent to the South Dakota Department of Health (SD DOH) regarding resident 13 revealed: *The resident had fallen while being assisted by certified nursing assistant (CNA) J. *The resident hit her head on the corner of the table and received a cut to her forehead. *She was sent to the clinic where they determined she had a broken nose. *She received staples to the top of her right eye and forehead. *CNA J had not used the gait belt (belt device used to help move an individual from one surface to another, or while walking an individual who may have balance problems) while transferring the resident from her recliner to her wheelchair. *The provider had determined there was no neglect and had given CNA J a verbal reprimand regarding the use of the gait belt.</p> | F 224 | <p>Administrator, DON, governing board and medical director reviewed and revised as necessary policies and procedures about ensuring potential abuse and negligence are appropriately investigated and reported.</p> <p>DON or designee will provide education on 8/10/2015 for facility staff to ensure potential abuse and negligence are appropriately investigated and reported. All new employees will be provided education with orientation process.</p> <p>DON or designee will perform audits on gait belt transfers and mechanical Hoyer lift usage to ensure potential abuse or neglect was not present for 4 weeks and monthly for eleven more months.</p> <p>DON or designee will present the audit findings at the monthly QAPI meetings for review.</p> | |
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| F 224 | <p>Continued From page 22</p> <p>Review of resident 13's 4/30/15 Minimum Data Set (MDS) assessment revealed she needed extensive assistance of one staff person when transferring.</p> <p>Interview on 7/14/15 at 8:50 a.m. with the director of nursing regarding resident 13's above incident revealed: *Using a gait belt was standard practice when assisting residents with transfers or walking. *CNA J had not used the gait belt and had not followed the appropriate protocol resulting in injury to the resident. *She agreed neglect had occurred.</p> <p>Review of the provider's 5/12/15 Resident Freedom from Abuse, Neglect, and Exploitation policy revealed neglect was "harm to an elder's or a disabled adult's health or welfare, without reasonable medical justification, caused by the conduct of a person responsible for the elder's or disabled adult's health or welfare, within the means available for the elder or disabled adult, including failure to provide adequate food, clothing, shelter, or medical care."</p> <p>Review of the provider's undated nurse's assistant job description revealed they were responsible for: **"Handling and treating residents in a manner conducive to their safety and comfort." **"Adhering to instructions issued by nurse and to established routine." **"Performing duties in accordance with established methods and techniques and in conformance with recognized standards."</p> <p>Surveyor: 22452</p> | F 224 | | | |

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| F 224 | Continued From page 23 2. Review of resident 14's 5/31/15 nursing progress notes revealed: *10:14 a.m. (behavior note)- "Resident told certified nursing assistant [CNA] that she wanted to get up at noon and sit up in her room for 15 minutes and then go back to bed. CNA replied that at noon we are all in the dining room passing trays and helping residents eat and could we get you up earlier. The resident replied no that she wanted to be gotten up at noon." *12:17 p.m. (behavior note)- "Resident put call light on at noon and wanted to get up and sit in her wheelchair. Writer replied that we are all in dining room for lunch, and we will get you up as soon as we are done. The resident replied that she was going to put her light on and just wait then." *1:51 p.m. (behavior note)- "Resident requested to speak to the nurse. Resident upset that call light was on for 40 minutes before it was answered. Explained to resident that everyone was in the dining room for lunch so there is nobody to even see that your light was on. Resident replied she knew but told them that I wanted up at noon. My daughter is going to be up here later and was going to raise cain. Nurse replied you know that lunch is at noon and everyone is in the dining room and it's just not feasible to do that. Nurse asked her how about tomorrow we get up at 11:00 a.m. and that way we can get you layed back down before lunch. Resident replied that might work." *2:20 p.m. (behavior note)- "Resident was just helped to bed by CNAs. Nurse went back to see how the soup went down and resident was in bed and coughing up clear phlegm [saliva]. Resident reported she was so sick and she was up too long. The hospital had told her she should be up only 15 minutes at a time at the most and she | F 224 | | | |

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| F 224 | <p>Continued From page 24</p> <p>was up way too long. CNAs got resident up at 1:45 p.m. and she was layed back down at 2:15 p.m. Resident just kept saying she was so sick and was up too long."</p> <p>Interview on 7/14/15 at 10:30 a.m. with the director of nursing regarding resident 14 revealed:</p> <p>*The resident could often be very demanding. She would often tell her daughter one thing and tell the staff something else.</p> <p>*The provider was aware that answering residents' call lights during meal times was a problem.</p> <p>*They had talked frequently about rearranging staff during meal times, so someone would be available to answer call lights. But they had not actually done anything about it yet.</p> <p>*She confirmed that daily from 12:00 noon to 12:30 p.m. and from 5:00 p.m. to 5:30 p.m. if a resident turned on their call light it might be at least thirty minutes or more before a staff member would answer the light.</p> <p>*They did not have any CNAs on the nursing wings at mealtimes to answer lights. All the CNAs were to be in the dining room passing trays and assisting residents to eat.</p> <p>*During the week the administrative staff might answer a resident's call light to see what they needed and let the nursing staff know. The nursing staff though would not honor the residents' request until they were done in the dining room.</p> <p>*On weekends and during the supper meal there was not usually the administrative staff to help with call lights.</p> <p>*During the noon meal both nurses were usually done passing their medications in the dining room and would possibly help with call lights if they</p> | F 224 | | |

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| F 224 | <p>Continued From page 25</p> <p>were able.</p> <p>*One nurse would usually go to lunch, and the other nurse was usually charting.</p> <p>*She confirmed there often would not be a nurse in the dining room while the residents were eating. She had not thought about that until it was brought to her attention by the surveyor.</p> <p>*She agreed not answering residents' call lights for at least thirty minutes during meals could be a problem if a resident had a medical emergency.</p> <p>*They just had not come to the right solution on how to solve residents' call lights to be answered during meals.</p> <p>Surveyor: 33265</p> <p>3. Observation on 7/9/15 at 10:45 a.m. of resident 6 being transferred from her recliner to her bed using a mechanical lift revealed:</p> <p>*One of the multiple mechanical lifts was being utilized.</p> <p>*CNAs B and C were assisting the resident to move from her chair to her bed.</p> <p>*When hooking up the four lift straps to the four hooks, one hook was not utilized.</p> <p>-CNA B had placed both the sling lift straps onto the back hook instead of one being on the back and one on the front.</p> <p>*They were ready to start the lift with the straps as described above. This surveyor stopped them from attempting to raise the resident and asked the CNAs if the straps were positioned appropriately. This surveyor pointed out the empty hook.</p> <p>-CNA C stated "we would have noticed that eventually."</p> | F 224 | | | |

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| F 224 | <p>Continued From page 26</p> <p>Record review and interview with the director of nursing (DON) on 7/14/15 at 10:20 a.m. regarding the resident sliding out of sling on 4/4/15 revealed:</p> <p>*Incident note in electronic medical record stated a certified nursing assistant (CNA) was attempting to transfer the resident to her bed from her wheelchair. The resident slid out of the mechanical lift sling, because it was not positioned properly under the resident.</p> <p>*The 4/4/15 Fall Investigation Worksheet revealed:</p> <p>-The resident had fallen on 4/4/15.</p> <p>-The resident had been seated in her wheelchair in her room.</p> <p>-A CNA had attempted to use a mechanical lift to transfer the resident to her bed. The mechanical lift sling had moved, and the resident slid out. The resident was lowered to the floor by a CNA.</p> <p>-The resident was not injured.</p> <p>-Two CNAs were listed on the document, but the DON was not sure who placed sling, who operated the lift, or who lowered the resident to the floor based on the documentation.</p> <p>-The DON could not identify from the documentation which mechanical lift or sling was involved in the incident.</p> <p>Further interview with the DON on 7/14/15 at 10:20 a.m. regarding the above observation on 7/9/15 revealed they:</p> <p>*Had not done skills testing with employees on using a mechanical lift during the last year.</p> <p>*Would do training if there was a concern.</p> <p>Review of provider's 5/12/15 Resident Accident Prevention policy and procedures revealed:</p> <p>*An accident was described as an unexpected,</p> | F 224 | | | |

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| F 224 | Continued From page 27 unintended event that could cause resident bodily injury. *All reports would be reviewed quarterly at Safety Meetings and Quality Assurance Meetings for number or pattern of accidents and corrective actions. | F 224 | | | |
| F 226 SS=E | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to thoroughly investigate bruises and major injuries of unknown origin for three of three sampled residents (5, 9, and 21) to determine if abuse or neglect had occurred. Findings include: 1. Review of resident 5's initial and five-day investigation report sent to the South Dakota Department of Health (SD DOH) revealed: *On 1/21/15 he was found on the floor lying on his back by an unidentified certified nursing assistant (CNA) at 0345 (3:45 a.m.). *His head was slightly under the bed. *He had hit his head on the bedframe. *He complained of pain to his wrist, but no swelling or bruising had been noted at the time of | F 226 | F226 Investigation on incidents for Residents 5 & 9 will not be completed due to length of time passed since incident occurred. Resident 21 is no longer in the facility. Investigations on all other residents will be thoroughly completed to determine if abuse or neglect has occurred. Investigation report forms updated to include a more thorough investigation process. Administrator, DON, governing board, and medical director reviewed and revised as necessary policies and procedures about ensuring potential abuse and negligence are appropriately investigated and reported. DON or designee will provide education on 8/10/2015 for facility staff to ensure potential abuse and negligence are appropriately investigated and reported. All new employees will be provided education with orientation process. | 8/12/2015 | |

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| F 226 | <p>Continued From page 28 the incident. *They applied ice. *At 8:30 a.m. they made an appointment with his physician due to continued complaints of pain to his wrist. *It was determined he had a fracture to his wrist. *There had been no documentation of interviews conducted with the staff working at the time of the incident. *There had been no documentation regarding the investigation into when he had last gone to the bathroom, when he was last checked on, who had been working with him, environmental concerns, medication usage that could have contributed to the fall, or if the care plan had been followed.</p> <p>Surveyor: 22452 2. Review of resident 9's 1/4/15 Minimum Data Set assessment revealed his Brief Interview for Mental (memory) Status (BIMS) score was 4 (indicative of severe memory impairment).</p> <p>Review of resident 9's 9/21/14 through 7/5/15 nursing progress notes revealed documentation regarding bruised (discolored areas) of unknown origin: *9/21/14, Bruise to navel (bellybutton). *12/7/14, Bruised areas to left hip, left side, and left and right upper arms. *2/8/15, Yellow/light lavender bruises noted to the back of the left knee and upper right forearm. Areas appear to be non-healing. *2/15/15, Continues to have bruises to left lateral (side) knee, left shin (front of lower leg), and the right knee. *3/1/15, Bruise to the back of his right hand and multiple bruising noted on both upper arms. *4/12/15, Bruise to the back of his left hand.</p> | F 226 <i>weekly</i> | <p><i>*two pw/sooth/jj</i></p> <p>DON or designee will perform audits on incident reports to ensure thorough investigations of bruises and major injuries of unknown origins took place to determine if abuse or neglect had occurred for 4 weeks and monthly for eleven more months.</p> <p>DON or designee will present audit findings at the monthly QAPI meetings for review.</p> | |
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| F 226 | <p>Continued From page 29</p> <p>*7/5/15, Has bruising to left elbow.</p> <p>Interview on 7/8/15 at 2:00 p.m. with the director of nursing regarding resident 9 revealed: *They knew the bruises on his hands were likely from when he had bloodwork done, but they had not documented that. *The other bruises they had not investigated and should have since the resident was not able to tell them how he had obtained them.</p> <p>Surveyor: 32335 3. Review of resident 21's initial and five-day investigation report sent to the SD DOH revealed: *On 1/15/15 at 11:55 a.m. CNA K had reported to the nurse on duty the resident appeared to be in discomfort when being repositioned. Something appeared to be wrong with her leg. *Upon assessment the nurse had noticed facial expressions of pain when moving her leg. *They sent her to the clinic to be assessed by the physician. *The physician found a spiral fracture (a bone fracture occurring when torque [force that tends to rotate] is applied along the axis of a bone) of the right upper leg. *On 1/15/15 the director of nursing (DON) had interviewed three CNAs and two registered nurses (RN). *CNA D had reported giving her a bed bath on 1/14/15 at 11:45 a.m. and noticed it was easier, because she did not seem as contracted. *CNA M had worked with her on 1/13/15 and 1/14/15 during the evenings and noticed on 1/14/15 it was easier to complete care, and her right leg moved more freely. It had not been like that on 1/13/15. *CNA C had worked with her on 1/13/15 and 1/14/15. She had "noticed her leg was loose while</p> | F 226 | | |

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| F 226 | <p>Continued From page 30</p> <p>helping [staff member's name] complete a bed bath on 1/14/15 at 11:45 a.m."</p> <p>*The DON had reported assisting the resident with breakfast on 1/14/15 at 8:30 a.m. and had not noticed any facial expressions when moving the head of the bed up.</p> <p>*RN N stated there were no reports of changes to the resident's right leg on 1/14/15.</p> <p>*RN O had assisted the resident with eating on 1/14/15 at 11:30 a.m. and had not noticed any facial expressions when she put the head of the bed up.</p> <p>*They had determined the fracture had actually occurred on the morning of 1/14/15 but had not found any staff to be at fault.</p> <p>*There had been no documentation on how they had made that determination when they identified the fracture had occurred on 1/14/15, the day before the concern was reported.</p> <p>*There had been no follow-up interviews conducted with any of the staff.</p> <p>Interview on 7/14/15 at 8:50 a.m. with the DON regarding resident 21 revealed:</p> <p>*Resident 21 had very contracted (shortened) muscles.</p> <p>*She felt a spiral fracture could have happened because the resident was so contracted.</p> <p>*She felt her staff were not responsible.</p> <p>*She had no documentation to support the spiral fracture could have happened without any force being applied.</p> <p>*CNAs D, M, and C should have reported to the charge nurse the change in the resident's condition on 1/14/15 due to them being mandatory reporters.</p> <p>*She had not followed up with any of the CNAs when she had determined the timeframe of when the fracture had occurred.</p> | F 226 | | | |

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| F 226 | Continued From page 31 4. Review of the provider's 5/12/15 Resident's Freedom From Abuse, Neglect, and Exploitation policy revealed: *Staff are mandatory reporters of suspicions of abuse, neglect and exploitation." *Failure to report with the knowledge of these occurrences may result in person being charged with a felony." *Staff should have completed an incident report when abuse or neglect were expected. *The administrator, DON, and social worker were to complete a full investigation of all reported suspicions of abuse. *The policy had not covered how an investigation should have been completed. | F 226 | | | |
| F 241 SS=E | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Surveyor: 33265 Based on observation, interview, and policy review, the provider failed to: *Engage and involve four of four residents (17, 22, 23, and 24) assigned to the first seating of the noon meal in prayer before the meal or in any activity following the completion of the meal. *Assist two of two randomly observed unidentified | F 241 | F241 Care plans of Residents 17, 22, 23, 24 were reviewed to ensure proper dignity and respect of individuality is being followed during meal time. Resident 10's care plan was reviewed to ensure staff awareness of resident's visual impairment and proper notification upon entering room. All other resident care plans who receive dining assistance during the first phase of meal time will be reviewed to ensure proper dignity and respect of individuality is being followed during meal time. All other resident care plans with visual impairment will be reviewed to ensure staff awareness and proper notification upon entering room. | 8/12/2015 | |

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| F 241 | <p>Continued From page 32</p> <p>residents who needed assistance eating. *Ensure staff knocked and announced themselves when entering the room of one of one sampled resident (10) who was visually impaired. Findings include:</p> <p>Surveyor: 32335 1. Observation on 7/7/15 from 12:00 noon through 12:45 p.m. revealed: *At 12:00 noon residents 17, 22, 23, and 24 were moved into the area adjacent to the dining room with the television (TV) on the wall. *They had finished eating. *They were placed approximately 10 feet away from the wall and facing the wall. *The TV had been off. *The second group of residents had entered the dining room for lunch and were sitting behind those four residents. *During the above mentioned timeframe no staff had checked on those residents or attempted to turn on the TV. *At 12:00 noon a prayer was said for all the residents in the second group.</p> <p>Surveyor 34030 2. Observation on 7/7/15 of the evening meal revealed: *Resident 23 and an unidentified resident were seated at the back of the dining hall at a table second from the left next to the west wall by the partition. *At 5:15 p.m. they were served their meal. *They sat there without eating and appeared unsure of what to do. *They were not being assisted to eat. -Observations during the noon meal that same day revealed they had been assisted with eating. *An unidentified certified nursing assistant (CNA)</p> | F 241 | <p>Administrator, DON, social services and interdisciplinary team reviewed and revised as necessary the policies and procedures about providing care with dignity and respect.</p> <p>Social Services Director or designee will provide education on 8/10/2015 for facility staff to ensure care is provided with dignity and respect. All new employees will be provided education with orientation process.</p> <p>Social Services Director or designee will perform audits on resident's requiring dining assistance and those who are visually impaired to ensure dignity and respect was given for 4 weeks and monthly for two more months* or until directed otherwise by the QAPI Committee. <i>AW/SAOH/JJ</i></p> <p>Social Services Director or designee will present findings at the monthly QAPI meetings for review.</p> | | |

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| F 241 | <p>Continued From page 33 at the next table stated "They usually feed themselves." *At 5:35 p.m. a staff person sat down to assist them. She fed one resident a few bites and asked the other if she would eat if she "warmed up her food". -She did not warm up the food. *At 5:40 p.m. the staff person left the table. The two residents continued to sit at the table without eating.</p> <p>Surveyor 33265 3. Continued observation of the above two residents on 7/7/15 during the evening meal revealed one of the two unidentified residents received assistance with eating from an unidentified staff member at 5:55 p.m. That was forty minutes after receiving her meal.</p> <p>Surveyor: 32335 4. Observation and interview on 7/8/15 from 4:00 p.m. through 4:40 p.m. with resident 10 revealed staff did not always knock and announce themselves. She was visually impaired and could not see. She stated she could recognize some staff voices but not all of them. She also stated she did not know if they were going to work with her or with her roommate when they did not announce themselves. She stated there was a note on the door to remind staff to knock and announce themselves. During the interview an unidentified staff member entered the room without knocking or announcing herself. She had come into the room to work with the roommate.</p> <p>5. Interview on 7/14/15 at 8:50 a.m. with the director of nursing revealed: *Seven residents who needed assistance with</p> | F 241 | | |

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| F 241 | Continued From page 34 eating ate at 11:30 a.m. *Residents 17, 22, 23, and 24 were four of those seven. *All other residents ate at 12:00 noon. *The prayer was only said at 12:00 noon and was not said for the seven residents needing assistance. *She agreed the prayer should have been said for all residents. *Staff should not have placed residents 17, 22, 23, and 24 in front of the TV when it was not on. *She was unaware staff were not knocking or announcing themselves when entering resident 10's room. *She stated there was a sign on the door to prompt them to knock and announce themselves before entering. Review of the provider's 6/5/15 Quality of Life - Dignity policy revealed each resident should be cared for in a manner that promoted and enhanced quality of life, dignity, respect, and individuality. Staff should have kept the resident informed and orientated to their environment and explained procedures before they were performed. | F 241 | | | |
| F 248 SS=E | 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: | F 248 | F248 Care plans for Residents 2 and 10 were reviewed to ensure individualized activities were implemented. Care plans for all other visually impaired residents were reviewed to ensure individualized activities were implemented. | 8/12/2015 | |

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| F 248 | <p>Continued From page 35 Surveyor: 22452</p> <p>Surveyor: 35625 Based on observation, record review, interview, and policy review, the provider failed to implement individualized activities for two of two visually impaired residents (2 and 10). Findings include:</p> <p>1. Review of resident 2's complete medical record revealed: *He had a diagnosis of vascular dementia (forgetfulness), glaucoma (increased fluid pressure in the eye), macular degeneration (loss of vision), and legal blindness (disability related to loss of vision). *The 6/19/15 quarterly Minimum Data Set (MDS) assessment noted his vision to be severely impaired. *The 6/30/15 care plan did not contain any information regarding group or one-to-one activities for him.</p> <p>Review of resident 2's 4/1/15 through 7/13/15 activity report sheets revealed: *His participation was recorded with church services, movies, reading, newspaper, social time, listening to television, visitor, music, sensory group, and one-to-one time. *No documentation was available describing his level of participation and response to the above activities.</p> <p>Observation on 7/7/15 at 11:05 a.m. of resident 2 revealed: *He was not doing an activity while sitting in his wheelchair at a small table in the activity area of dining room. *He was faced away from the activity group of</p> | F 248 | <p>Activity Director and Administrator reviewed and revised as necessary the policy and procedure about the provision of activities especially those with visual impairment.</p> <p>Activity Director will provide education for all staff responsible for facilitating an activity to ensure visually impaired residents' needs are met. All new activity employees will be provided education with orientation process.</p> <p>Activity Director or designee will perform audits to ensure proper activities for visually impaired residents' are offered <i>for 4 weeks and monthly for two more months*or until directed otherwise by the QAPI Committee.</i></p> <p>Activity Director or designee will present <i>findings at the monthly QAPI meetings for review.</i></p> | | |

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| F 248 | <p>Continued From page 36</p> <p>residents for greater than ten minutes. *There was no interaction with staff or peers during that time.</p> <p>Observation on 7/7/15 at 5:00 p.m. of resident 2 revealed: *He was sitting in his wheelchair in his room. *He did not have the television or radio on for stimulation. *There was no interaction with staff or peers at that time.</p> <p>Interview on 7/13/15 at 12:00 noon with the activity director regarding resident 2 revealed: *He would become agitated and yelled out in a group setting. *There was no consistent one-to-one schedule or specific activities for him regarding his yelling about family and farming. *She confirmed activities for him were not individualized to accommodate his visual impairment or agitation.</p> <p>Surveyor: 32335 2. Interview on 7/8/15 from 4:00 p.m. through 4:40 p.m. with resident 10 revealed: *She was visually impaired. *She had been in the facility for approximately three years. *She had lost her eyesight approximately three months after her admission into the facility. *Her husband had lived in the facility and passed away in February 2015. *She had books on tape and liked to listen to music in her room. *She attended Bingo, but there was not much else she could do regarding activities. *She used to work with computers. *She used to grow roses.</p> | F 248 | | |

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| F 248 | <p>Continued From page 37</p> <ul style="list-style-type: none"> *When she first lost her sight two certified nursing assistants (CNA) orientated her to her room and the dining room. *Since then no one had taken the time to orientate her to any other parts of the building. *She would like to see if she could learn to use a cane to get around. *She had gained weight since being in the facility. *She used to be more mobile, but since she lost her sight all she did was sit in her wheelchair or recliner. *She would like to go out of the facility more often. *She felt like she was ignored and was depressed. *Once every few weeks the activities director would take a group out of the facility and she would go along. *The social worker only visited her every few months to ask her a "bunch of questions." <p>Review of resident 10's 5/26/15 care plan revealed she:</p> <ul style="list-style-type: none"> *Liked to listen to the radio with headphones. *Had raised dogs and grew roses. *Enjoyed listening to sports. *Preferred country music. *Had worked as a nurse. *Attended Bingo, but that had not been on the care plan. No other activities were listed on the care plan. <p>Review of resident 10's 2/18/15 and 5/14/15 MDS assessments revealed:</p> <ul style="list-style-type: none"> *It was very important to her to participate in or have access to the following activities: -Reading materials. -Music. -Animals. | F 248 | | | |

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| F 248 | <p>Continued From page 38</p> <ul style="list-style-type: none"> -News. -Favorite activities. -Being outside. -Religion. <p>*It was somewhat important for her to be involved in group activities.</p> <p>Interview on 7/14/15 at 8:30 a.m. with the activities coordinator regarding resident 10 revealed:</p> <ul style="list-style-type: none"> *They did one-to-one activities with her that consisted of reading her mail and visiting with her. *She was not aware that she wanted to learn to use a cane to walk. *Her niece had bought her computer software awhile back to install on her laptop, so she could use the computer again. *The laptop was too old to install the software. *She had not followed-up on looking into getting a different computer for her. *They had not had her do any activities with gardening or flowers. *They had not developed any activities regarding animals or being outside. *They had not been in touch with any outside agencies to learn more about activities for the visually impaired. <p>3. Review of the provider's April 2014 One-to-One Program policy revealed:</p> <ul style="list-style-type: none"> *The facility was to provide a variety of activities to fulfill physical and mental needs. *The activity department would include residents in group or one-to-one activities adapted to their abilities. *Activity suggestions were: <ul style="list-style-type: none"> -Ball throwing. -Singing. | F 248 | | |

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| F 248 | Continued From page 39 -Parties/Programs. -Rhythm Band. *One-to-one activity ideas were: -One-to-one walks. -Dancing. -Music. -Sorting clothes. -Sorting towels. -Sorting blocks or colors. -Working out of sensory box. -Rubbing lotion on arms. | F 248 | | |
| F 250 SS=E | 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: 22452 Surveyor: 35625 Based on record review, interview, and job description review, the provider failed to make available appropriate social services for 4 of 15 sampled residents (2, 7, 10, 15) with increased psychosocial needs. Findings include: 1. Review of resident 2's medical record revealed: *An admission date of 12/6/12. *Diagnoses of vascular dementia (forgetfulness), glaucoma (increased fluid pressure in the eye), gout (arthritis), high blood pressure, legal | F 250 | F250 Resident 2 was reviewed to ensure proper communication with family regarding psychosocial needs took place. Resident's PCP will be contacted for appropriate diagnosis for antipsychotic medication. PCP will be consulted to determine appropriateness for psychosocial counseling services. All other residents with psychosocial needs will be reviewed to ensure proper communication with family took place, appropriate diagnoses, and physician consultation to determine appropriateness for psychosocial counseling services. Resident 15 is no longer in the facility. Social Services Director will notify local ombudsman for potential services to assist residents financially and at home. | 8/12/2015 |

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| F 250 | <p>Continued From page 40</p> <p>blindness (disability related to loss of vision), and macular degeneration (loss of vision).</p> <p>*He was hospitalized at an inpatient behavioral health facility from 9/17/13 through 10/4/13.</p> <p>*Outpatient therapy sessions were conducted and concluded in 2013.</p> <p>*He had episodes of increased agitation when he would yell out and show increased movement.</p> <p>*He was prescribed Haldol (a mood and behavior altering medication) 2.5 milligrams (mg) every twelve hours as needed for agitation by his primary care physician.</p> <p>*There was no documentation of social service interactions from 4/1/15 through 7/7/15.</p> <p>Review of resident 2's 4/23/15 physician's progress note revealed: *" [resident's name] is seen for nursing home rounds. He is doing well. Staff is not having concerns for him." *No changes were made to the plan of care on that visit.</p> <p>Review of resident 2's 6/8/15 physician's progress note revealed: *"He is doing reasonably well. Staff has no concerns for him at this time." *No changes were made to the plan of care on that visit.</p> <p>Review of resident 2's 6/30/15 reviewed and updated care plan revealed: *" [resident's name] may be having pain when he displays physical and disruptive behaviors, monitor for pain and use appropriate interventions." *"Provide a calm and quiet environment, prefers dim lighting." *"Contact family for one-on-one when staff unable</p> | F 250 | <p>Social Services Director will speak with Resident 7 regarding continued desire for a facility transfer. At request of resident, Social Worker will continue referral outreach to other facilities.</p> <p>Social Services Director will assist all other residents and/or families to contact potential facility transfers and provide referral information to said facility. Social Services Director will contact local ombudsman for outside referral services.</p> <p>Resident 10's care plan was reviewed and revised to include appropriate goals and interventions.</p> <p>All other care plans of residents with increased psychosocial needs will be reviewed to ensure appropriate goals and interventions are included.</p> <p>Social Services Director and Administrator reviewed and revised as necessary the policy and procedure about the provision of social</p> <p>services especially those with identified increased psychosocial needs.</p> <p>Social Services Director or designee will provide education to all staff responsible for provision of social services and addressing resident psychosocial needs.</p> | | |

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| F 250 | <p>Continued From page 41 to redirect [resident name]."</p> <p>***Document all negative behaviors and report to charge nurse."</p> <p>***PRN [as needed] Haldol may be utilized when all other options have been exhausted, monitor for effectiveness."</p> <p>Interview on 7/7/15 at 4:40 p.m. with the social worker regarding resident 2 revealed no progress notes were available due to having "no problems" with the resident.</p> <p>Interview on 7/8/15 at 8:15 a.m. with the director of nursing and the social worker regarding resident 2 revealed:</p> <ul style="list-style-type: none"> *The episodes of agitation had increased over the last several months. *The primary care physician had not been notified of the change in the resident's status. *They were unable to provide documentation of interventions attempted with the resident prior to administering the Haldol. *Increased episodes of agitation were not discussed on care conferences with the family. *Additional interventions that would have been beneficial to the resident had not been discussed. *No consideration was given for outside services to assist with the increased behavioral disturbances. <p>2. Review of resident 15's medical record revealed:</p> <ul style="list-style-type: none"> *She was admitted to the facility from an inpatient hospitalization on 3/2/15. *She was discharged home with family on 5/13/15. *Diagnoses of urinary tract infection, weakness, hypothyroidism (underactive thyroid), hypertension (high blood pressure), macular | F 250 | <p>Social Services Director or designee will perform audits on Residents 2, 7, 10, and 2 other residents to ensure appropriate social services was available to residents with increased psychosocial needs for 4 weeks and monthly for eleven more months.</p> <p>Social Services Director or designee will present findings at the monthly QAPI meetings for review.</p> | | |

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| F 250 | <p>Continued From page 42</p> <p>degeneration (loss of vision), and congestive heart failure (heart cannot pump enough blood to meet the body's needs).</p> <p>*The plan at admission was for the resident to remain at the facility long-term after rehabilitation services had ended.</p> <p>*A physician's order on 5/11/15 stated for the resident to be discharged to home on home health services and with medications.</p> <p>-Medications were not sent with the resident due to Medicare A limitations.</p> <p>-Home health services were not in place at the time of discharge.</p> <p>-There was no documentation to the physician regarding the change in plan of care.</p> <p>*On 5/11/15 at 12:11 p.m. an interdisciplinary progress note was made by the social worker:</p> <p>-The resident's financial assistance application had been denied.</p> <p>-Family was going to return the resident to her home, and she would receive services there.</p> <p>-The resident's daughter was given information about home health services, and the social worker offered her assistance.</p> <p>Interview on 7/9/15 at 10:25 a.m. with the social worker regarding resident 15's discharge revealed:</p> <p>*The resident's family was handling the application for financial assistance that had been denied.</p> <p>*She had offered assistance with services but stated the family had opted to handle it on their own.</p> <p>*Confirmed that home health services were not in place at the time of the resident's discharge from the facility.</p> <p>*No consideration was given to contacting the ombudsman (resident advocate) regarding</p> | F 250 | | | |

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| F 250 | <p>Continued From page 43 potential services for the resident. *There was no documentation in the medical record regarding the resident's discharge plan and instructions.</p> <p>3. Review of resident 7's 2/11/15 through 5/21/15 social services notes revealed: *The resident had expressed to staff she wanted to move closer to her family in the western part of the state. *A referral to a facility had been denied due to their inability to meet her wound care needs. -She expressed her disappointment to social service staff. -Staff encouraged the resident to "continue to work on healing her wound." *There was no documentation provided regarding additional services or support offered to the resident regarding a facility transfer.</p> <p>Interview on 7/8/15 at 8:45 a.m. with the director of nursing (DON) and the social worker revealed: *The resident's wound status had improved since her admission to the facility. *Acknowledged that no additional support or services were in place to help facilitate a transfer to a different facility.</p> <p>Surveyor: 32335 4. Review of resident 10's medical record revealed: *She had an admission date of 9/26/12. *She had lost her eyesight approximately three months after her admission.</p> <p>Interview on 7/8/15 from 4:00 p.m. through 4:40 p.m. with resident 10 revealed: *She was visually impaired. *Her husband had lived in the facility and passed</p> | F 250 | | | |

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| F 250 | <p>Continued From page 44 away in February 2015.</p> <p>*She felt like she was ignored and was depressed.</p> <p>*When she first lost her sight two certified nursing assistants (CNA) orientated her to her room and the dining room.</p> <p>*Since then no one had taken the time to orientate her to any other parts of the building.</p> <p>*She would like to see if she could learn to use a cane to get around.</p> <p>*She had gained weight since being in the facility.</p> <p>*She used to be more mobile, but since she lost her sight all she did was sit in her wheelchair or recliner.</p> <p>*She would like to go out of the facility more often.</p> <p>*The social worker only visited her every few months to ask her a "bunch of questions."</p> <p>Review of resident 10's interdisciplinary notes from 1/9/15 through 7/8/15 revealed:</p> <p>*There were three notes written by the social worker.</p> <p>*On 6/30/15 the resident requested to visit with the social worker to discuss her code status .</p> <p>*On 5/19/15 the social worker had completed the MDS assessment. The resident had reported she had thoughts of hurting herself.</p> <p>-She "notified the DON, all nursing staff, as well as _____ [counselor name], resident counselor from _____ [counseling service name]."</p> <p>-There had been no documentation in the notes she had notified the physician.</p> <p>*On 4/21/15 the social worker had spoken to her about a new roommate.</p> <p>*There had been no other documentation from the social worker regarding the resident.</p> <p>Review of resident 10's 5/26/15 care plan</p> | F 250 | | | |

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| F 250 | <p>Continued From page 45 revealed:</p> <ul style="list-style-type: none"> *An undated goal to monitor for depressed mood. They referred to counseling services. *Another undated goal to monitor for suicidal thoughts and tendencies. They completed a mood assessment quarterly and with change of condition. *There were no other social service goals or interventions documented on the care plan. <p>Interview on 7/14/15 at 9:25 a.m. with the social worker regarding resident 10 revealed:</p> <ul style="list-style-type: none"> *She had not made any adaptations to the resident room or her belongings to help her be more independent. *She had not made any community referrals to address needs related to her visual impairment. *She had not identified any sensory stimulation (activities that make use of the five senses) for the resident. *She had referred the resident to a counseling service who visited her at the facility for her depression. <p>Surveyor: 35625</p> <p>5. Review of the provider's undated job description for the Social Services Director revealed:</p> <ul style="list-style-type: none"> *Duties included working with an interdisciplinary team to provide support to residents and families/representatives, so they could cope with acute and chronic illnesses. *They would counsel residents, advise family, and assist in the development of the resident's needs and concerns by means of one-to-one visits, checklists, interviews, and care planning. *They would assess the resident's needs throughout their stay to maintain a care plan that addressed social, emotional, and psychosocial | F 250 | | |

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| F 250 | Continued From page 46 needs. *He/she would continue to monitor the resident's needs and utilize outside resources as needed. *"The social service designee will be responsible in documenting the discharge plan in the resident's medical record and will follow up as necessary to ensure the resident's safety and appropriateness of the resident's new setting." *"Be a resident advocate at all times and inform residents of his/her rights throughout their stay." *"Behavior prevention and management-work together to prevent behaviors of residents and manage them appropriately. Interventions and non-pharmaceutical routes are to be examined and documented before use of medications to manage a behavior. Documentation is critical and is required." | F 250 | | | |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, record review, and policy review, the provider failed to maintain: *Clean fans at the end of each wing. *Clean air conditioner vents in the two air conditioners in the activity room. *Cleanable wood surfaces under each window air conditioner. *Preventative maintenance and housekeeping logs. Findings include: | F 253 | F253 Fans, air conditioner vents, and wood surfaces under each window air conditioner were inspected to ensure they were clean or able to be cleaned. Preventative maintenance and housekeeping logs were reviewed to ensure they were complete and accurate. A tracking log for the cleaning and inspecting of the fans, vents, air conditioning units, and wood surfaces under each window air conditioner will be created and distributed to the housekeeping staff. Environmental Service staff will be educated on the procedure during their first available shift. | 8/12/2015 | |

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| F 253 | <p>Continued From page 47</p> <p>1. Observation on 7/7/15 from 8:00 a.m. through 9:00 a.m. throughout the facility revealed: *Large wall mounted fans at the end of each resident wing had a dirty from grill. *The air vents in both aid conditions in the activity room had visible dirt. *Each window air conditioner had been placed on an untreated wooden board. The raw wood surface was uncleanable and had rough edges.</p> <p>Interview on 7/8/15 at 8:50 a.m. with the maintenance director concerning the cleaning of fans revealed he had a preventative maintenance notebook and a housekeeping notebook with logs.</p> <p>Review of the preventative maintenance notebook received from the maintenance director revealed: *The log sheets for daily, weekly, monthly, and quarterly preventative measures for 2014 were filled in. *The daily log sheet had not included any Saturdays or Sundays. *The 2015 quarterly assessment worksheet log was filled in. *The semi-annual log for 2015 was misdated with dates from both January 2015 and December 2015. *The remainder of the worksheets for 2015 were not completed and included the daily, weekly, monthly, annual, prior to heating season, and prior to cooling season preventative measures. *The two year, four year, five year, ten year, and twelve year logs had not been started.</p> <p>Further interview on 7/8/15 at 9:15 a.m. with the maintenance director revealed:</p> | F 253 <i>weekly</i> <i>rw/SDPH/JJ</i> | <p>Environmental Services Director or designee will perform audits on tracking logs to ensure they are complete and accurate for four weeks and monthly for two more months ^{or} until directed otherwise by the QAPI committee. Environmental Services Director or designee <i>rw/SDPH/JJ</i> will present findings at the monthly QAPI meetings for review.</p> | |
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| F 253 | <p>Continued From page 48</p> <p>*He had not found the housekeeping notebook. Fans should have been on the housekeeping quarterly log.</p> <p>*He believed the above preventative maintenance notebook had all the worksheets or logs for 2015 in it.</p> <p>Further interview on 7/8/15 at 4:17 p.m. with the maintenance director revealed the: *Cleaning of the fans was left off of the 2015 log sheets. The housekeeping notebooks for both 2014 and 2015 were requested again.</p> <p>*Preventative maintenance worksheet logs for 2015 were at another facility he worked at.</p> <p>Further interview on 7/9/15 at 9:05 a.m. with the maintenance director revealed he:</p> <p>*Could not locate the housekeeping notebook for 2014 or 2015.</p> <p>*Was present every day including Saturdays and Sundays and had completed the duties on the daily worksheet but had not completed the documentation for those days.</p> <p>*Was not sure of the date the present preventative maintenance system went into place which was when the baseline for the two, four, five, ten, and twelve year worksheets should have been completed.</p> <p>Interview on 7/14/15 at 8:40 a.m. with the administrator revealed he agreed:</p> <p>*The equipment and building needed to be maintained in clean, working order.</p> <p>*The maintenance and housekeeping logs should Have been kept up to date and available for review.</p> <p>Policies concerning the maintenance and housekeeping preventative measure logs were</p> | F 253 | | | |

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| F 253 | Continued From page 49 requested. None were received before the end of the survey. | F 253 | | | |
| F 280 SS=E | <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on observation, record review, interview, and policy review, the provider failed to update and/or revise care plans for 7 of 15 sampled residents (1, 2, 3, 6, 7, 9, and 14). Findings include:</p> <p>1. Random observations of resident 2 from 7/7/15 through 7/9/15 and from 7/13/15 through 7/14/15</p> | F 280 | <p>F280</p> <p>Care plan for Resident 2 was updated to reflect discontinuation of personal alarm, Foley catheter use, interventions for falls, and change of active pressure ulcers to at risk for skin breakdown. Care plan for Resident 7 was updated to reflect active skin ulcer conditions. Care plan for Resident 9 was updated to reflect accurate transfer, bruising, use of Foley catheter and UTI's, discontinuation of personal alarm, fall interventions, weight loss and nutritional needs, and repositioning for pressure ulcer prevention. Resident 14 is no longer in the facility. Care plan for Resident 3 was updated to reflect usage of a grab bar, fall mat, walker, and interventions for falls. Care plan for Resident 6 was updated to reflect Foley catheter care, pressure ulcer prevention, and fall prevention.</p> <p>All other resident care plans will be updated to include but not limited to catheter use, interventions for falls, pressure ulcer prevention and treatment, bruising, ADL ability, infections, weight loss and nutritional needs.</p> <p>DON and interdisciplinary team reviewed and revised as necessary the policy and procedure about care plan creation, review, and revision.</p> | 8/12/2015 | |

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| F 280 | <p>Continued From page 50 revealed: *No personal alarm was in place to alert staff when the resident attempted to self transfer. *He had an indwelling Foley catheter (tube inserted into the bladder to drain urine).</p> <p>Review of resident 2's 4/8/15 physician's orders revealed an order for insertion of a Foley catheter and to change the catheter monthly.</p> <p>Review of resident 2's 6/27/15 through 7/7/15 nursing progress notes revealed no documentation of any pressure ulcers during the weekly skin assessments.</p> <p>Review of resident 2's 6/30/15 reviewed and updated care plan revealed he was: **"At increased risk for falls, personal alarm to alert staff when he gets up." **"Incontinent of bowel and bladder and wears a brief (disposable incontinent product) for incontinence." **"Impaired skin integrity, unstageable pressure ulcer to right heel."</p> <p>Interview on 7/7/15 at 3:15 p.m. with registered nurse (RN) H regarding resident 2 revealed: *He had no pressure ulcers currently. *His personal alarm had been discontinued in June 2015. *No other interventions for fall prevention had been addressed. *A Foley catheter was currently in place.</p> <p>2. Review of resident 7's 4/23/15 nursing progress notes revealed an ulceration to the right inner thigh had healed.</p> <p>Review of resident 7's 5/7/15 nursing progress</p> | F 280 | <p>DON or designee will provide education to all staff responsible for care plan process, review and revision.</p> <p>DON or designee will perform ^{* ten-twelve} audits on ^{Dwlsorath JJ} identified care plans to ensure they are complete and accurate per individualized resident for four weeks and monthly for two more months.</p> <p>DON or designee will present findings at the monthly QAPI meetings for review.</p> | |

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| F 280 | <p>Continued From page 51</p> <p>note revealed an ulceration to the gluteal fold (area where buttock and thigh meet) had opened on 5/4/15.</p> <p>Review of resident 7's 5/7/15 physician's orders revealed an order for a dressing change to wound the gluteal fold.</p> <p>Review of resident 7's 6/30/15 reviewed and updated care plan revealed *"See treatment administration record for daily pressure ulcer treatments, pressure ulcers to bilateral legs." *No documentation was present on the care plan regarding the gluteal fold ulceration.</p> <p>Interview on 7/8/15 at 8:45 a.m. with the director of nursing (DON) regarding resident 7 revealed: *She had one current pressure ulcer to the right gluteal fold. *The pressure ulcer had recently been infected, and the resident had been treated with antibiotics. Surveyor: 22452</p> <p>3. Review of resident 9's 6/24/15 physician's orders revealed: *Change Foley catheter (tube inserted into the bladder to drain urine) once a month. *Push fluid every shift for urinary tract infection. *Okay to have arm rest on toilet. *Okay to have handrail on bed for repositioning.</p> <p>Review of resident 9's 9/17/14 through 7/7/15 nursing progress notes revealed he: *Had four falls on 9/17/14, 3/20/15, 5/5/15, and on 5/17/15 when he was attempting to transfer himself. *Had bruises of unknown origin on his arms, legs, and on his knees on 9/21/14, 12/7/14, 2/8/15, 2/15/15, 3/1/15, 4/12/15, and on 7/6/15.</p> | F 280 | | |

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| F 280 | <p>Continued From page 52</p> <ul style="list-style-type: none"> *Was repositioned three to four times each shift. *Was transferred with the use of a stand-aide (mechanical lift that required resident to be able to bear weight on legs). *Had a gel cushion (type of pressure relieving cushion) in his wheelchair. *Participated in a restorative program to maintain his strength, endurance, and walking ability. *Was frequently incontinent (no control) of bowels. *Had a Foley catheter inserted on 4/14/15 related to urine retention (unable to urinate or empty bladder). The catheter was removed on 4/21/15, 5/6/15, and on 5/11/15 and was re-inserted immediately each time as he was unable to void. *Was on an antibiotic for a urinary tract infection on 4/14/15 for ten days, 6/18/15 for ten days, and on 7/1/15 for seven days. *Had been encouraged with fluids (there was no documentation regarding what amount had been encouraged and how much he had accepted). *Was not to be left alone in his room. There was documentation on 5/5/15 that had been communicated to the family. *Had a progressive weight loss. *Was to have been encouraged at meals to help improve intake. *Was to receive supplements with meals and for snacks. <p>Review of resident 9's 4/20/15 reviewed and updated care plan revealed: ***"At risk for falls and nutritional status." ***"Requires limited assistance of one with transfers." -There was no documentation regarding the use of the stand-aide. ***"Will participate in scheduled bowel and bladder toileting to keep as dry as possible and promote</p> | F 280 | | |

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PRINTED: 07/28/2015
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435129 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 07/14/2015 |
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| NAME OF PROVIDER OR SUPPLIER DELLS NURSING AND REHAB CENTER INC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 THRESHER DR DELL RAPIDS, SD 57022 | | |
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| F 280 | <p>Continued From page 53</p> <p>skin integrity."</p> <p>-There was no documentation regarding the use of the Foley catheter, the bowel incontinence, the urinary tract infections, or the physician's order to push fluids every shift.</p> <p>*"He wears a personal alarm to alert staff when he tries to transfer self as he does not always remember to ask for assistance."</p> <p>-This was documented as discontinued on 6/2/15.</p> <p>*There was no documentation he was not to be left alone in his room.</p> <p>*There was no documentation regarding his weight loss, or his need to be encouraged at meals.</p> <p>*There was no documentation regarding his frequent bruises, or that he was to be repositioned every three to four hours.</p> <p>4. Review of resident 14's medical record revealed she had been hospitalized from 5/27/15 to 5/30/15 for pneumonia (lung infection), gastritis (stomach inflammation), and clostridium difficile (C-diff) (bacteria in the intestines that causes diarrhea [loose stools]).</p> <p>Review of resident 14's 6/1/15 through 6/18/15 nursing progress notes revealed she:</p> <p>*Frequently refused meals or to go the dining room.</p> <p>*Had poor food and fluid intake.</p> <p>*Had loose stools related to the C-diff.</p> <p>*Had frequent complaints of pain in her left leg.</p> <p>*Would not consistently accept pain medication.</p> <p>*Had told the nursing staff on 6/14/15 she thought she had a blood clot in her left leg.</p> <p>*Frequently refused to get out of bed, and she only wanted to be up in the wheelchair for very short periods of time.</p> <p>*Had multiple bruised areas on her body noted</p> | F 280 | | |

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| F 280 | <p>Continued From page 54 when she had returned from the hospital. *Had a frequent cough with sputum (saliva) production. *Was hospitalized on 6/18/15 for weakness, anemia (low iron in her blood), and blood clots in her legs.</p> <p>Review of resident 14's 5/8/15 reviewed and updated careplan revealed it had not been updated after her hospitalization regarding the above areas.</p> <p>5. Interview on 7/8/15 at 2:30 p.m. with the director of nursing (DON) regarding the above residents' care plans revealed: *She knew a lot of their care plans had not been kept updated. *The Minimum Data Set (MDS) assessment nurse was the one responsible to keep them updated. *She was not sure how much the certified nursing assistants really used the care plans. Surveyor: 34030</p> <p>6. Observation on 7/7/15 during the initial tour revealed resident 3's room: *Had a grab bar at the top half of his bed. *A fall mat beside his bed. *A wheel chair and a walker.</p> <p>Observation and interview on 7/8/15 at 10:00 a.m. with resident 3 revealed he used a wheelchair in the morning. He then used a walker to help him ambulate the rest of the day.</p> <p>Review of resident 3's medical record revealed: *He had a grab bar for repositioning. *He had falls, and the one on 4/16/15 resulted in an injury and hospital stay.</p> | F 280 | | |

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| F 280 | <p>Continued From page 55</p> <p>*He used a walker.</p> <p>Review of resident 3's 9/19/14 care plan had a hand written "reviewed and updated" date of 6/2/15 on it and revealed: ***"Utilizes wheelchair for locomotion." **"At risk for falls..." *No mention had been made of the grab bar on his bed or the fall mat. *The care plan had not been updated to show he used his walker. *Nothing was mentioned about specific falls or interventions for those falls. Surveyor: 32335 7. Review of resident 1's 4/8/15 care plan revealed it had not addressed the eight falls he had from 9/1/14 through 7/7/15 including his fall on 3/24/15 that resulted in a left hip fracture. None of the interventions had been documented on the care plan. Refer to F323, findings 3 and 4.</p> <p>Surveyor: 33265 Review of resident 6's 4/21/15 care plan revealed the plan had not included: *Foley catheter care to be completed every shift. *Changing the Foley catheter monthly. *The option of prn (as needed) medication orders for creams to assist in prevention and or treatment of pressure ulcers. *A fall on 4/4/15 from the mechanical lift sling (type of equipment used to move the resident from one place to another) and possible preventative measures for the future.</p> <p>8. Interview on 7/13/15 at 3:20 p.m. with the DON revealed she agreed there were items that should have been added and updated on the care plan.</p> <p>Review of provider's 6/3/15 Comprehensive Care</p> | F 280 | | |

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| F 280 | Continued From page 56 Plan policy revealed: *Each resident's care plan was to have included: -Identified problem areas. -Risk factors associated with identified problem areas. -Resident's wishes regarding care and treatment goals. -Identification of who was responsible for each part of resident's care. -Steps for preventing a decline in resident's daily functioning (ability to care for self). -Focus on rehabilitative program. -Current recognized standards of practice for problem area and conditions. *Assessments of the residents were to be ongoing with the care plans revised as information about the resident and his or her condition changed. *The Care Planning/Interdisciplinary Team was responsible for the review and updating of the care plan. | F 280 | | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on record review, interview, and policy review, the provider failed to clarify the code status (cardiopulmonary resuscitation if heart stops and other emergency response) for 1 of 15 sampled residents (6). Findings include: 1. Record review and interview on 7/14/15 at | F 281 | F281 Physician progress note for Resident 6 was updated to reflect accurate code status. All other residents' progress notes were reviewed to ensure accurate code status. DON and interdisciplinary team reviewed and revised as necessary the policy and procedure about code status. DON or designee will provide education for all staff responsible for accurate documentation of code status. | 8/12/2015 | |

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| F 281 | Continued From page 57 10:20 a.m. with the director of nursing (DON) regarding resident 6 revealed: *The Advanced Directives/Treatment Options/Code Status form dated 8/10/12 identified the resident wanted to be a full code (receive emergency treatment) and was signed by her physician. *The Medication Review Report dated 5/26/15 identified her to be a full code. *The Care Plan dated 7/24/14 documented resident to be a full code. *The physician progress notes dated 5/26/15 identified the resident to be a no code (not wanting emergency treatment). *She believed the resident wanted to be a full code. *She stated the physician's progress notes were reviewed by the charge nurses when received. *She agreed the charge nurse should have noticed the progress notes were different and clarified the order with the physician. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, MO., 2013, p. 305 revealed: "If the health care providers confirms an order and you (the nurse) still believe that it is inappropriate, inform the supervising nurse or follow the established chain of command. p. 350 revealed: "The record is the most current and accurate continuous source of information about a patient's health care status." p. 362 revealed: "Interdisciplinary communication is essential within the health care team." | F 281 | DON or designee will perform audits on code status accuracy in progress notes for four weeks and monthly for two more months. DON or designee will present findings at the monthly QAPI meetings for review. | | |
| F 283 SS=D | 483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS | F 283 | F283 Resident 15 is no longer in the facility. | 8/12/2015 | |

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| F 283 | <p>Continued From page 58</p> <p>When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35625</p> <p>Surveyor: 22452 Based on closed record review, interview, and policy review, the provider failed to make available documentation of the discharge summary for one of one sampled resident (15) who was discharged home. Findings include:</p> <p>1. Review of resident 15's 5/11/15 physician's order revealed "Discharge to home with home health services and medications."</p> <p>Review of resident 15's 5/13/15 interdisciplinary progress notes revealed: *She was discharged to home without medications. *Home health services had not been set-up per family request. *There was no documentation a discharge summary had been completed and sent with the resident. Refer to F157, finding 4.</p> <p>Interview on 7/9/15 at 11:40 a.m. with the director of nursing regarding resident 15 revealed she:</p> | F 283 | <p>Facility will ensure all other residents were provided with proper discharge summaries upon discharge from facility. A copy will also be retained by the facility for resident's medical record.</p> <p>DON and interdisciplinary team reviewed and revised as necessary the policy and procedure about discharge summary recapitulation.</p> <p>DON or designee will provide education on discharge summary recapitulation for all staff responsible for this task.</p> <p>DON or designee will perform audits on discharge summary completion for four weeks and monthly for two more months.</p> <p>DON or designee will present findings at the monthly QAPI meetings for review.</p> | |

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| F 283 | Continued From page 59 *Was sure a discharge summary had been completed and sent home with her. *Was unable to locate a copy of the discharge summary that should have been in her medical record. Review of the provider's 6/3/15 Discharge Summary and Plan policy revealed: **"A copy of the post discharge plan and summary would be provided to the resident, any receiving facility, and retained in the resident's medical record." **"The post discharge plan will be developed by the care planning/interdisciplinary team with the assistance of the resident and his/her family and will contain at a minimum: -A description of the resident's and family's preferences for care. -A description of how the resident and family will access such services. -A description of how the care should be coordinated if continuing treatment involves multiple caregivers. -The identity of specific resident needs after discharge (personal care, physical therapy, etc). -A description of how the resident and family need to prepare for the discharge." **"The social service department will review the plan with the resident and family twenty-four hours before the discharge is to take place." | F 283 | | | |
| 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 | F 309 | F309 Resident 14 is no longer in the facility. Resident 7's pain will be assessed and physician notified of any change in pain status. | 8/12/2015 | |

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| F 309 | <p>Continued From page 60 and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to ensure: *A change in condition for one of one sampled resident (14) was appropriately assessed, treated, and documented. *Pain was addressed and managed for one of one sampled resident (7). Findings include:</p> <p>1. Review of resident 14's medical record revealed: *A 7/3/13 admission date. *Diagnoses: chronic airway obstruction (difficulty breathing), chronic kidney disease, and history of deep vein thrombosis (DVT) (blood clots in the legs that cause swelling or pain but may occur without symptoms.) *She had been hospitalized from 5/27/15 to 5/30/15 for pneumonia (lung infection), gastritis (stomach inflammation), and clostridium difficile (bacteria in the intestines that causes diarrhea [loose stools]). *She was alert and oriented (memory okay).</p> <p>Review of resident 14's June 2015 medication administration record revealed she was on Xarelto (medication that prevents the formation of blood clots) daily.</p> <p>Review of resident 14's 6/14/15 through 6/25/15 nursing progress notes revealed: *6/14/15 at 9:51 p.m.- "Resident denied any pain</p> | F 309 | <p>Physicians will be notified immediately of all other residents who have a change of condition including but not limited to complaints of pain, swelling, injury from fall, pressure ulcers, and notification of orders not being completed.</p> <p>DON and interdisciplinary team in collaboration with the medical director reviewed, revised, and/or created as necessary the policy and procedures about assessment for change in condition and pain management.</p> <p>DON or designee will provide education on 8/10/2015 for facility staff on appropriate assessment for change in condition and pain management. All new employees will be provided education with orientation process.</p> <p><i>* two audits</i> DON or designee will perform audits on select residents for proper physician notification and pain management for four weeks and monthly for eleven more months.</p> <p>DON or designee will present findings at the monthly QAPI meetings for review.</p> | |

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| F 309 | Continued From page 61 times three this shift. Resident called writer down to room related to her left leg. She stated she thought she had a blood clot. Leg was examined. Leg is free from any swelling and able to wiggle toes. Bruising noted to lower shins [front of lower legs]. Informed resident there was no evidence of a DVT, but will pass on to monitor." *6/15/15 at 1:02 a.m., "Resident complains of left leg pain." *6/15/15 at 4:50 a.m., "Resident complains of left knee and leg pain." *6/15/15 at 5:04 a.m., "Resident repositioned every two hours and asked about pain level. She did express having pain within her left knee and and leg and nurse gave her as needed [PRN] Tramadol [pain medication] which was effective. Resident is pale [white] and hard to awaken when checked on." *6/15/15 at 11:49 a.m., "Tramadol given for pain. Asked where her pain was and stated my left foot and left knee. Rated pain 7 out of 10 [on a 1 to 10 scale with 1 being minimal pain and 10 being severe pain]." *6/16/15 at 10:36 p.m., "Weekly skin assessment completed. Resident has 2+ edema [swelling on a 1+ to 4+ scale 1+ is minimal swelling and 4+ is severe swelling]. No complaints of pain." *6/17/15 at 8:04 a.m., "Resident rated pain at 7 out of 10 each time when asked throughout the night. Refused pain medication. Resident appeared to have no pain and looked comfortable." *6/17/15 at 7:49 p.m., "Asked resident if she had pain and she said not very much. Recommended she take something for pain so it would not get any worse. She wanted Tramadol. Got the Tramadol, gave it to resident and asked her where her pain was and how bad it was. She stated it was in her left leg and it was about a 9 | F 309 | | |

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| F 309 | Continued From page 62 out of 10. Asked her how her pain went from not much to a 9 and she stated she did not know." *6/18/15 at 1:00 a.m., "Asked resident what her pain level was. She said 7 out of 10. She showed no signs and symptoms of pain and looked like she was comfortable. This nurse advised her if she needed something that I would bring something to her. Will continue to monitor through the night." *6/18/15 at 2:42 p.m., "Talked to daughter about transportation to hospital to get peripherally inserted central catheter [PICC] [catheter inserted into the vein in an arm that goes directly into the heart]. I explained to her that if she goes to the local hospital that she would be fine going by wheelchair van. I told her to go by ambulance that the doctor will have to fill out paperwork for insurance to pay." *6/18/15 at 3:45 p.m., "Resident transferred to hospital by ambulance. Possible admission for respiratory issues." *6/19/15 at 9:17 a.m., "Writer called hospital to check on resident's status. She was admitted to the hospital with diagnosis of weakness and anemia [low iron in blood]." *6/22/15 at 4:14 p.m., "Daughter states her mother was not doing well and is in intensive care unit. The c-diff is taking over and she has blood clots in her legs that are moving. There is nothing they can do for her." *6/23/15 at 9:30 a.m., "Received phone call from daughter and resident is being moved to a hospice [end-of-life] house. She stated she will be up to get her belongings after she passes [dies]." *6/25/15 at 8:24 a.m., "Resident passed away." Interview on 7/14/15 at 10:00 a.m. with the DON regarding resident 14 revealed: *The physician should have been called on | F 309 | | | |

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| F 309 | <p>Continued From page 63</p> <p>6/14/15 when the resident told the nurse she had a blood clot in her leg.</p> <p>*The resident was alert, but she would often tell the nursing staff one thing and tell her daughter something else.</p> <p>*An increase in edema in the left leg on 6/16/15 also should have been reported to the physician, and her continued complaints of pain in the leg. The Tramadol had been effective to control her pain when she would accept it from the nursing staff.</p> <p>*The nurse should not have told her on 6/14/15 she had no evidence of a DVT until she had spoken to the physician.</p> <p>Review of Patricia A. Potter and Anne Griffen Perry, Fundamentals of Nursing, 8th Edition, St. Louis Mo., 2013, pages 1133-1134 and 1149 revealed:</p> <p>*Some signs and symptoms of DVT would include swelling usually in one leg and/or leg pain or tenderness.</p> <p>*Some patients (residents) experience no symptoms.</p> <p>*Usually the clots form in the legs and can be fatal (deadly) if the clots travels to the lungs.</p> <p>**Report suspected DVT to the healthcare provider immediately."</p> <p>Surveyor: 35625</p> <p>2. Review of resident 7's 5/29/13 physician's order revealed Oxycodone (narcotic pain medication) extended release 30 milligrams (mg) twice a day</p> <p>Review of resident 7's 4/14/15 physician's order revealed Tramadol (a pain medication) 50 mg every eight hours as needed.</p> <p>Review of resident 7's 4/20/15 physician's order</p> | F 309 | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435129 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/14/2015 |
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| NAME OF PROVIDER OR SUPPLIER DELLS NURSING AND REHAB CENTER INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 THRESHER DR DELL RAPIDS, SD 57022 | |
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| F 309 | <p>Continued From page 64 revealed Tramadol 100 mg every eight hours.</p> <p>Review of resident 7's 4/16/15 physician's progress note revealed she was under his care for pain management.</p> <p>Review of the 10/9/14 Minimum Data Set (MDS) assessment regarding resident 7 revealed pain: *Intensity at 10 on a 0-10 numeric scale (0 was no pain to 10 was severe pain). *Frequency was almost constant. *Interfered with sleep and activities.</p> <p>Review of the 6/19/15 MDS assessment for resident 7 revealed pain: *Intensity was severe. *No documentation on a 0-10 numeric scale was given. *Frequency was almost constant. *Interfered with sleep and activities.</p> <p>Review of resident 7's 6/30/15 care plan revealed: *"Administer scheduled and as needed [PRN] medication for pain management in a timely manner." *"Assess for pain every shift and administer PRN Tramadol for breakthrough pain, and monitor effectiveness of PRN medications."</p> <p>Interview on 7/8/15 at 4:25 p.m. with resident 7 regarding her pain revealed: *She felt her medication helped for only a short time but wore off too quickly and the pain returned. *She told registered nurse (RN) A about her increased pain "a few weeks ago" to the region of the current and healed pressure ulcer in the buttock region.</p> | F 309 | | |

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| F 309 | <p>Continued From page 65</p> <ul style="list-style-type: none"> -RN A told the resident he would send a facsimile to the physician in the morning. -No response or feedback was given to her regarding a response from physician. -She did not inquire about a physician response from RN A or any other nurse. -No reason was given for her not following up with staff. <p>Interview on 7/8/15 at 5:00 p.m. with RN A regarding resident 7's pain revealed he:</p> <ul style="list-style-type: none"> *Was unable to recall the period of time referenced with the resident stating she had increased pain *Had not made any contact with the physician recently regarding her pain. *Thought it could be related to a change in treatment to her pressure ulcer at that time. *Had not completed a pain assessment with resident 7 when she had increased complaints with her pressure ulcer treatment changes. <p>Interview on 7/9/15 at 9:40 a.m. with the DON regarding resident 7 revealed:</p> <ul style="list-style-type: none"> *Pain assessments were always completed with a quarterly MDS assessment. *It was her expectation that a pain assessment would have been completed for a change in level of pain. *All pain management was handled through the resident's primary care physician. *The resident had not been assessed or treated at a pain clinic. No reason was given for that lack of referral. *Stated resident 7 "will always say she has pain." <p>Review of the provider's 6/3/15 Pain-Clinical Protocol policy revealed nursing staff were to assess for pain:</p> | F 309 | | |

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| F 309 | Continued From page 66 *On admission to the facility. *At quarterly review. *When there was a significant change in condition. *With onset of new pain or worsening of existing pain. | F 309 | | | |
| F 311 SS=E | 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to consistently follow the restorative walk-to-dine program for one of one sampled resident (1) who had recently broken his hip. Findings include: 1. Observation on 7/7/15 from 11:50 a.m. through 12:00 noon of resident 1 revealed: *He had been in his room talking with the social worker. *She pushed him in his wheelchair down to the dining room. Observation on 7/8/15 at 8:55 a.m. of resident 1 revealed he was in therapy. He had just gotten done with the bike. He got up and walked using his front wheeled walker and gait belt. He went from the therapy room to his room with the therapist walking beside him with the wheelchair behind him. He walked without problems. | F 311 | F311 Resident 1's restorative walk-to-dine program was reviewed to ensure it was complete and accurate in charting to make sure documentation reflected care given. All other residents receiving restorative walk-to-dine program were reviewed to ensure they were complete and accurate in charting to make sure documentation reflected care given. DON or designee will perform audits to ensure walk-to-dine program is complete and accurate for 4 weeks and monthly for 2 more months. DON or designee will present findings at the monthly QAPI meetings for review. | 8/12/2015 | |

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| F 311 | <p>Continued From page 67</p> <p>Review of resident 1's 4/8/15 care plan revealed he was on a walk-to-dine program. He was supposed to "walk to meals up to 3x/day [three times per day] with a gait belt and FWW [front wheeled walker]."</p> <p>Review of resident 1's restorative nursing records from 7/1/15 through 7/7/15 revealed:</p> <ul style="list-style-type: none"> *He was to walk to meals up to three times a day to maintain walking ability and strength up to seven days per week. One assist with gait belt and front wheeled walker. *They had documented he had walked one out of twenty-one opportunities. *There were three other entries that said "out." *There was no documentation for seventeen of the twenty-one opportunities. <p>Interview on 7/8/15 at 9:20 a.m. with the Minimum Data Set (MDS) assessment coordinator revealed:</p> <ul style="list-style-type: none"> *She oversaw the restorative program. *Residents were on the walk-to-dine program to help maintain or improve their strength. *She thought resident 1 was walked only one time per day on the walk-to-dine program. *She had no documentation on how that would have been decided. *She agreed the documentation for all residents was not consistent regarding the walk-to-dine program. *She had reviewed past months and had blanks where nothing was documented. *She had not followed-up on missing documentation for any of the months reviewed. *She agreed the program was not consistent. <p>Review of the provider's 7/22/13 Restorative Nursing policy revealed:</p> | F 311 | | |

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| F 311 | Continued From page 68 *The program was developed for residents to return or maintain their highest practicable physical, mental, and psychological functional level and well being. **"Instituting an individualized, effective program means a program will be implemented to assure an individual will not deteriorate or diminish unless circumstances, such as a progressive deteriorating condition, makes the decline unavoidable." **"Measurable objectives and interventions must be documented in the resident's care plan and medical record." **"Documentation tracks progress or regression. Document towards the care plan. Charting goals and approaches. The care care plan should be updated as resident status changes." | F 311 | | | |
| F 314 SS=E | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on observation, record review, interview, and policy review, the provider failed to assess, intervene, and treat three of three sampled residents (1, 6, and 7) with pressure ulcers (injury | F 314 | F314 Primary care physician will be updated on Resident 1,6,7's pressure ulcer changes weekly. Care plans will also be updated to include interventions for respective residents. Primary care physician will be updated on all residents with pressure ulcers weekly. Care plans will also be update to include interventions for all residents. Wound nurse educated on dressing change policy. Nursing staff educated on reporting change of condition to nurse. <i>* Wound nurse received additional education with AMT Consultant on 8/11/15. DW/SDOAH/JJ</i> | <i>8/12/2015</i> | |

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| F 314 | <p>Continued From page 69 to skin usually from pressure and frequently over a bony area). Findings include:</p> <p>1. Review of resident 7's medical record revealed: *Her initial admission was on 5/23/13. *She had been readmitted following a hospitalization on 10/2/14. *Diagnoses included chronic skin ulcerations (sores), diabetes mellitus type 2 (lack of blood sugar control), depression, and neurogenic bladder (damage to the nerves that affect urination). *She had one unstaged pressure ulcer to the right gluteal fold (area where the thigh and buttock meet) that had opened on 5/4/15. *A 10/22/14 physician's order stating the resident was not to sit up for more than two hours at a time. *The 6/19/15 quarterly Minimum Data Set assessment identified a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen. That score indicated she was cognitively intact (memory okay) with no impairment.</p> <p>Review of resident 7's weekly observation tool from 5/4/15 through 7/9/15 regarding her wound revealed: *On 5/7/15 through 5/28/15 she had an unstaged pressure ulcer acquired on 5/4/15 to the left gluteal fold (inaccurate documentation per interview with director of nursing). -It measured 20 millimeters (mm) in length by 7 mm in width on 5/7/15 and 5/13/15. -It measured 15 mm in length by 3 mm in width on 5/21/15. -It measured 13 mm in length by 3 mm in width on 5/28/15. -Wound cleanser was used, and a sorbsan</p> | F 314 | <p>DON and interdisciplinary team in collaboration with the medical director reviewed and revised as necessary the policies and procedures about assessment, care and intervention, prevention of pressure ulcers.</p> <p>DON or designee will provide education on 8/10/2015 for facility staff on appropriate assessment, care and intervention, prevention of pressure ulcers. All new nursing staff employees will be provided education with orientation process.</p> <p>DON or designee will perform audits* to ensure physician notification regarding skin updates, clean dressing procedures followed, and interventions added to care plans* for 4 weeks and monthly for 2 more months* or until directed otherwise by the QAPI committee. DON or designee will present findings at the monthly QAPI meetings for review.</p> <p><i>on those identified with skin concerns</i></p> | <p><i>* weekly DW/500H/JJ * or DW/500H/JJ</i></p> | |

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| F 314 | <p>Continued From page 70</p> <p>wound dressing (type of dressing to promote wound healing) was applied.</p> <p>*On 6/4/15 she had an unstaged ulcer to the right gluteal fold.</p> <p>-It was acquired on 5/4/15.</p> <p>-The wound measured 13 mm in length by 3 mm in width.</p> <p>-Wound cleanser was used, and a sorbsan wound dressing was applied.</p> <p>-There was no further documentation provided regarding a wound to the left gluteal fold.</p> <p>*On 6/11/15 the same right gluteal fold measured 13 mm in length and 3 mm in width.</p> <p>-Wound cleanser was used, and a sorbsan wound dressing was applied.</p> <p>*On 6/18/15 the same right gluteal fold measured 25 mm in length by 5 mm in width.</p> <p>-Wound cleanser was used, and a sorbsan wound dressing was applied.</p> <p>-Evaluation of the wound by RN A stated "Wound remains the same with no change..."</p> <p>-No documentation of physician notification and recommendations were provided with that change in wound status.</p> <p>*On 6/25/15 the same right gluteal fold measured 25 mm in length by 5 mm in width.</p> <p>-Wound cleanser was used, and a sorbsan wound dressing was applied.</p> <p>-Facility awaiting wound culture results.</p> <p>*On 7/2/15 the same right gluteal fold measured 25 mm in length by 5 mm in width.</p> <p>-Wound cleanser was used, and a sorbsan wound dressing was applied.</p> <p>*On 7/9/15 the same right gluteal fold measured 20 mm in length by 5 mm in width.</p> <p>-Wound cleanser was used, and a sorbsan wound dressing was applied.</p> <p>-Evaluation of the wound by registered nurse (RN) A stated "Wound has slight improvement as</p> | F 314 | | | |

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| F 314 | <p>Continued From page 71 it is smaller in size. Will report to skin and nutrition teams."</p> <p>Review of a 5/7/15 physician's order regarding resident 7's gluteal fold wound revealed she was to have a sorbsan dressing pad applied twice daily to the wound.</p> <p>Review of a 6/4/15 physician's order regarding resident 7's wound revealed the frequency of the dressing change of the sorbsan dressing was increased to three times a day.</p> <p>Review of a 6/27/15 physician's order regarding resident 7's wound culture revealed: *An order for Keflex (an antibiotic used to fight bacteria) 500 milligrams three times a day for ten days. *Wound culture revealed the presence of escherichia coli (a bacteria often found in the gastrointestinal tract).</p> <p>Review of the 6/30/15 care plan for resident 7 revealed no documentation of a pressure ulcer to the right gluteal fold.</p> <p>Observation of the wound and dressing change for resident 7 was attempted but she declined to have a surveyor present.</p> <p>Interview on 7/7/15 at 3:25 p.m. with RN N regarding resident 7 revealed she had a wound to the right gluteal fold that required a dressing change three times a day.</p> <p>Interview on 7/8/15 at 4:25 p.m with resident 7 revealed: *She was able to reposition her self in bed with the use of the grab bar and trapeze bar on her</p> | F 314 | | |

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| F 314 | <p>Continued From page 72 bed. *Required staff assistance to transfer from wheelchair to bed. *She had become frustrated with staff several weeks ago related to a transfer. -Her call light was turned on at 7:00 p.m., because she was ready to go to bed. -Staff had assisted her to bed at approximately 10:30 p.m. -She estimated she had been sitting up for approximately five to six hours.</p> <p>Interview on 7/8/15 at 5:10 p.m. with RN A regarding resident 7 revealed: *He was the wound nurse at the facility. *He documented the status of the wounds weekly. *The resident had a history of non-compliance with her treatment plan.</p> <p>Interview on 7/9/15 at 9:40 a.m. with the director of nursing regarding resident 7 revealed: *The resident's skin issues and progress were discussed at a weekly interdisciplinary meeting. *The wound to the gluteal fold was incorrectly identified as being on the left side from 5/7/15 through 5/28/15. *The resident was scheduled for a consultation with a wound clinic on 7/14/15.</p> <p>Review of the provider's 6/4/15 Skin Protectant Policy and Protocol revealed: *"If a resident is at risk for skin breakdown, staff is to follow protocol on back of Braden assessment form. This includes starting a skin protectant/moisture barrier." *There was no documentation present regarding any application of a barrier/skin protectant. Surveyor: 32335</p> | F 314 | | | |

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| F 314 | <p>Continued From page 73</p> <p>2. Review of resident 1's medical record revealed:</p> <ul style="list-style-type: none"> *He had been admitted on 6/13/14. *He had one stage two pressure ulcer (a sore caused by unrelieved pressure that resulted in damage to tissue) upon admission. -It was on his right coccyx (tailbone). -It was healed on 9/10/14 approximately three months after his admission. *On 6/19/14 he had developed a stage two pressure ulcer on his left coccyx. -It had healed on 7/9/14. *They had used zinc oxide ointment for both pressure ulcers. *They had not changed treatment from 6/13/14 through 9/10/14. *Documentation of physician notification and recommendations during that timeframe had been requested, but none had been provided up to the end of the survey. <p>Review of resident 1's wound weekly observation tools from 1/7/15 through 7/10/15 regarding his right buttock revealed:</p> <ul style="list-style-type: none"> *On 1/7/15 he had a stage two pressure ulcer to his right buttock. *There had been a discrepancy on when it had started. -On 1/7/15 the date acquired had been 12/22/14. -On 1/16/15 the date acquired had been 1/15/15. -On 1/21/15 the date acquired had been 1/13/15. *From 1/7/15 through 3/5/15 they had used Clobetasol Propionate Ointment 0.05% for treatment. *From 3/12/15 through 4/9/15 they had used A&D ointment for treatment. *Comments included the following documentation: -On 1/21/15 "talked to resident about trying to lay | F 314 | | |

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| F 314 | <p>Continued From page 74 down more instead of sitting up in his recliner all day." -From 2/3/15 through 3/5/15 "Will discuss with Wound team about change of treatment options." -On 3/5/15 had added "Talk with dietician about increasing protein intake." -From 3/12/15 through 4/2/15 "Will meet with skin team and go over results and talk about further options to improve healing." -There had been no results of those interventions documented. *On 4/9/15 it was healed.</p> <p>On 5/17/15 the wound weekly observation tool documented he had acquired a stage two pressure ulcer to his right buttock. *From 5/17/15 through 5/28/15 they used A&D ointment for treatment. *From 6/4/15 through 6/18/15 they had used a foam dressing for treatment. *On 5/28/15 they documented "Worse [wound] is larger but looks better. Dietary intake very poor. Weight continues to go down slowly. Will talk with skin team about further treatment." *It was healed on 6/18/15.</p> <p>On 7/10/15 the wound weekly observation tool documented he developed one stage two pressure ulcer to his right buttock. They had used a foam dressing for treatment.</p> <p>Review of resident 1's wound weekly observation tools from 1/7/15 through 7/10/15 regarding his left buttock revealed: *On 1/16/15 he had a stage two pressure ulcer to his left buttock. *There had been a discrepancy on when it had started and healed. -On 1/16/15 the date acquired had been 1/15/15.</p> | F 314 | | |

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| F 314 | <p>Continued From page 75</p> <p>-On 1/21/15 the date acquired had been 1/13/15. -On 1/28/15 the date acquired had been 1/13/15 and documented it had healed. -On 2/25/15 the date acquired had been 1/13/15. -On 3/5/15 the date acquired had been 1/13/15 and documented it had healed. *From 1/16/15 through 1/21/15 they had used Clobetasol Propionate Ointment 0.05% for treatment. *From 1/28/15 through 3/5/15 they had used Calmoseptine for treatment. *They only comment that had been documented had been on 1/21/15 and it stated "Resident is encouraged to lay in bed more to sleep than up in his recliner."</p> <p>*On 5/17/15 the wound weekly observation tool documented he had developed a stage two pressure ulcer to his left buttock. *On 5/28/15 they had documented the pressure ulcer as being on the right buttock instead of the left. *On 6/18/15 it was healed. *From 5/17/15 through 5/28/15 they had used A&D ointment for treatment. *From 6/4/15 through 6/18/15 they used a foam dressing for treatment.</p> <p>*On 7/10/15 the wound weekly observation tool documented he had developed two stage two pressure ulcers to his left buttock. The treatment used had been a foam dressing.</p> <p>Review of resident 1's skin/wound notes from 1/2/15 through 7/10/15 revealed there was no documentation the physician had been notified regarding any of the above mentioned pressure ulcers.</p> | F 314 | | | |

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| F 314 | <p>Continued From page 76</p> <p>Review of resident 1's entire medical record revealed:</p> <p>*A fax from 5/28/15 to the physician stating "May we have an order for Hydrocellular foam dressing. Change BID [twice a day] to open areas on buttocks until healed."</p> <p>-There had been no explanation or description of the open areas.</p> <p>*Documentation of all other physician notification and treatment recommendations during the above timeframe's had been requested, but none had been provided up to the end of the survey.</p> <p>Review of resident 1's May 2015, June 2015, and July 2015 treatment administration records revealed:</p> <p>*There had been no A&D ointment ordered for the treatment of the pressure ulcers.</p> <p>*Clobeta Ointment Kit 0.05 and 2.3 percent (%) had been ordered on 3/24/15 and was to be applied to his left knee and right buttock topically (top of skin) every day shift related to circumscribed scleroderma (hard skin).</p> <p>*Hydrocellular foam dressing change twice a day to open areas on buttock had been ordered on 5/28/15 and discontinued on 6/18/15.</p> <p>-Hydrocellular dressing to buttocks every day and evening shift for skin ulcers had been ordered on 7/13/15 at 1508 (3:08 p.m.).</p> <p>*Calmoseptine ointment 0.44-20.6% had been ordered on 3/24/15 to apply to reddened areas topically as needed for protection twice a day.</p> <p>-It had only been applied one time on 5/21/15.</p> <p>Review of the provider's physician's protocols or standing orders signed on 6/19/14 by the physician revealed the pressure ulcer protocol included one multivitamin everyday, nutrition supplements three times per day, and to increase</p> | F 314 | | |

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| F 314 | <p>Continued From page 77 dietary protein.</p> <p>Review of resident 1's May 2015, June 2015, and July 2015 medication administration records (MAR) revealed he was not receiving a multivitamin.</p> <p>Review of resident 1's dietary notes from 1/29/15 through 6/25/15 revealed he was be be offered chocolate milk, 8 ounces (oz) carnation instant breakfast (CIB) with breakfast, 4 oz CIB with lunch, and "fortified double egg."</p> <p>Review of resident 1's 4/8/15 care plan revealed an area for "impaired skin integrity, pressure ulcer to coccyx." Interventions had been: *"Reposition 3-4 [times] a shift." *"See treatment book for current treatments." *"Pressure-reducing gel cushion in wheelchair." *"Air mattress overlay to his bed." *There were no other interventions listed.</p> <p>Interview on 7/13/15 at 1:45 p.m. with the DON regarding resident 1 revealed: *In March 2015 they had begun a weekly skin meeting to discuss the pressure ulcers. *The resident had three pressure ulcers that had reopened last week. *She was unsure how many pressure ulcers he had since admission. *She was unsure of when they had healed, when they had reopened, and what treatment had been used.</p> <p>Observation and interview on 7/13/15 at 2:10 p.m. with the DON and RN A regarding the cushion in resident 1's wheelchair revealed: *RN A was the wound nurse that handled the pressure ulcers at the facility.</p> | F 314 | | |

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| F 314 | <p>Continued From page 78</p> <ul style="list-style-type: none"> *The cushion was a maroon colored cushion about 1 inch thick. *They were both unaware of where the cushion had come from. *Neither recognized the cushion as one of the facility's. *They thought maybe the family had put the cushion in his wheelchair. *They both agreed having a pressure relieving cushion in his wheelchair was one of the interventions used to prevent pressure ulcers. *Neither could confirm the cushion was a pressure relieving cushion. *The DON had not made any referrals to physical therapy in regards to his wheelchair cushion. <p>Interview on 7/13/15 at 2:25 p.m. with the DON and RN A regarding resident 1 revealed:</p> <ul style="list-style-type: none"> *The DON had stated the treatments used were on the wound-weekly observation tool. *She had not provided any other documentation regarding physician ordered treatments. *There had been no documentation regarding physician notification regarding the pressure ulcers. *RN A stated three pressure ulcers had been discovered on 7/10/15. *He was unable to remember if he had notified the physician of the new pressure ulcers. *He had used the 5/28/15 treatment order for Hydrocellular foam dressing. *He should have notified the physician of the new pressure ulcers. <p>Surveyor: 33265 3. Observation and interview on 7/9/15 at 10:45 a.m. with certified nursing assistants (CNA) B and</p> | F 314 | | |

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| F 314 | <p>Continued From page 79</p> <p>C regarding resident 6's wound in the buttocks area revealed:</p> <p>*There were multiple small dark areas on the upper left thigh near the buttock area. None of those areas were open.</p> <p>*The coccyx (tailbone) area had an open area that was a one inch long slit in the skin. The area was pink in color with no drainage noted. Neither CNA had been aware of that opened area.</p> <p>Interview on 7/13/15 at 2:56 p.m. with the director of nursing revealed registered nurse A who had been doing the skin/wound assessments had not been aware of the opened area on resident 6's tailbone.</p> <p>Review of resident 6's medical record revealed a skin assessment was to have been done every Thursday by a nurse. The 4/21/15 care plan stated the resident was at risk for pressure ulcers. The CNAs were to do a daily skin inspection.</p> <p>Documentation on the following notes for resident 6 revealed:</p> <p>*Nutrition/Dietary 5/6/15 note identified a 0.5 by 0.5 area (unit of measure not given) on the right side of the buttocks close to the anus.</p> <p>*Health Status 5/7/15 note, the resident had one day left on antibiotics to treat sores on bottom.</p> <p>*Skin/Wound 5/14/15 note, there were no new wounds.</p> <p>*Skin/Wound 5/22/15 note, there was a red area on left buttock; other areas were healing.</p> <p>*Health Status 5/29/15 note, bottom area continued to be reddened.</p> <p>*Administrative 6/4/15 note, resident continued to have reddened areas. Skin was intact, they would continue to monitor.</p> | F 314 | | |

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| F 314 | <p>Continued From page 80</p> <p>*Physician order documented for Calmoseptine ointment to be applied to coccyx as needed for sore bottom. None had been documented as given for the first seven days of July 2015.</p> <p>*Skin/Wound 6/14/15 note, resident's right buttocks was red with a small crack starting. Stated Foley catheter would have to be put back in to prevent further problems with this area.</p> <p>-Foley catheter was re-inserted on 6/14/15.</p> <p>*Nutrition/Dietary 6/25/15 note, stated area on buttocks no longer open.</p> <p>4. Review of provider's 6/4/15 Skin Protectant policy and protocol revealed:</p> <p>*A resident at risk of skin breakdown was to have a skin protectant/moisture barrier started. The skin protectant was part of the standing orders of the physician.</p> <p>*Skin protectants were to be used for a resident who was incontinent (unable to control) of bowel and bladder functions.</p> <p>*The skin protectant was to be applied after the cleaning of the skin following each incontinent episode.</p> <p>*The skin protectant was to have been left in the resident's room for easy access by staff.</p> <p>Review of the provider's undated Skin Assessment Protocol revealed:</p> <p>*The Braden Scale (type of skin assessment) would be used to evaluate skin condition upon admission, readmission, quarterly, and with a significant change in condition.</p> <p>*To manage moisture they would:</p> <p>-Use commercial barrier (cream) for those residents who were incontinent of bowel or bladder functions.</p> <p>-Use absorbent pads that wick (pull away) and hold moisture.</p> | F 314 | | |

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| F 314 | <p>Continued From page 81</p> <ul style="list-style-type: none"> -Address cause if possible. -Offer the bedpan/urinal and a glass of water when turning residents. *To manage nutrition they would: <ul style="list-style-type: none"> -Increase protein intake. -Increase calorie intake to build proteins. -Add a multivitamin supplement. -Act upon any known deficits (something lacking) in the diet. -Utilize a dietician. *To manage friction and shear (damage to skin from pulling body part across fabric) they would: <ul style="list-style-type: none"> -Elevate the head of the bed no more than thirty degrees. -Use a trapeze bar (grab bar above upper part of body) when possible. -Use lift sheet to assist in moving a resident in the bed. -Protect the elbows and heels when possibility of friction was present. *To manage other general care issues they would: <ul style="list-style-type: none"> -Maintain good hydration. -Prevent dry skin. *Whenever a pressure ulcer was identified they were to follow the New Pressure Area Check List. The checklist included: <ul style="list-style-type: none"> -Contacting the physician, director of nursing, Minimum Data Set (assessment tool) coordinator, family, certified nursing assistants, and dietary. -Measuring and documenting the needed information regarding the pressure ulcer including completing an incident report. <p>5. Observation on 7/13/15 at 2:09 p.m. of resident 1's dressing change by registered nurse (RN) A with assistance of CNA G revealed: *CNA G was in resident 1's room with the resident in the bathroom.</p> | F 314 | | | |

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| F 314 | Continued From page 82 *RNA walked in with supplies (glove, dressing, and scissors) and laid them on the bedside stand without making a clean surface on which to place the clean supplies. *RNA opened the dressing packaging and then put on gloves. *CNA G positioned the resident for the dressing change. He was standing with assistance of CNA G at the bathroom doorway. *The gait belt had been placed around the resident's waist with the tail end of the gait belt hanging down in the middle of his buttocks. *He then pulled the tail end of gait belt out of the way of his vision with his right hand, so that the gait belt was against the resident's skin and dressing. He then pulled off the dressing over the wound on the left buttock revealing a jagged two inch long wound. *He then pulled the tail end of the gait belt to the left buttock and pulled off the dressing on the right buttock revealing a small open wound at the very bottom center area of the buttock *He discarded the used dressings, then picked up the scissors and dressing placing his thumb directly over the area on the dressing that would cover the wound. He cut the dressing to cover the area of the wound, placed the back of the dressing on the clear adhesive, and then placed the dressing over the wound on the lower right buttock and secured it in placed. *He repeated the same process again placing his thumb directly over the dressing material that would cover the wound, and placed the dressing and adhesive over the wound on the left buttock. *He did not clean either wound before applying the new dressing. *He took his gloves off, gathered the empty bandage wrapper and scissors, and left the room without washing his hands. | F 314 | | | |

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| F 314 | Continued From page 83 *He went to the medication room where the gloves and dressing packaging were discarded, and then washed his hands. *CNA G left resident 1's room wearing the gait belt around her waist that had touched the wounds and skin on resident 1's buttocks. Review of the provider's 6/3/15 Clean Dressing Change procedure revealed: *A clean field should have been made to put the clean supplies on. *Soiled dressings should have been placed in a plastic bag. *Soiled gloves should have been removed after the soiled dressings had been removed and discarded. *Wounds should have been cleaned. *Used gloves and disposable supplies should have been placed in a plastic bag when removed from the room. Interview on 7/14/15 at 10:20 a.m. with the director of nursing concerning the resident's dressing changes revealed she agreed the observed dressing change observed had not followed the provider's procedure. | F 314 | | | |
| F 315 SS=H | 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 | F 315 | F315 Fluid Input flow sheet has been added for Resident 9 to indicate amount of fluids received to follow physician's order. All other residents with a physician's order to push fluids will have a fluid input flow sheet implemented. | 8/12/2015 | |

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| F 315 | <p>Continued From page 84 function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335</p> <p>Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to ensure: *Interventions were followed to prevent recurrent urinary tract infections for two of two sampled residents (6 and 9) who had an indwelling Foley catheter (tube inserted into the bladder to drain urine). *One of two sampled residents (6) had a medical diagnosis to warrant the use of an indwelling Foley catheter. Findings include:</p> <p>1. Review of resident 9's 6/24/15 physician's orders revealed: *Change Foley catheter once a month. *Push fluid every shift for urinary tract infection.</p> <p>Review of resident 9's 4/14/15 through 7/7/15 nursing progress notes revealed he: *Had a Foley catheter inserted on 4/14/15 related to urine retention (unable to urinate or empty bladder). The catheter was removed on 4/21/15, 5/6/15, and on 5/11/15 and was re-inserted immediately each time as he was unable to void. *Was on an antibiotic for a urinary tract infection on 4/14/15 for ten days, 6/18/15 for ten days, and on 7/1/15 for seven days. *Had been encouraged to drink fluids (there was no documentation regarding what amount had been encouraged and how much he had accepted).</p> | F 315 | <p>Foley catheter was removed from Resident 6 on 7/30/2015. Care plan was updated to reflect removal and interventions were added for UTI prevention.</p> <p>All other residents with indwelling catheters will be assessed to indicate appropriate diagnosis and interventions utilized for UTI prevention.</p> <p>Individualized toileting programs for Residents 3, 5, 12 was reviewed and determined for program to be removed.</p> <p>All other residents utilizing individualized toileting program were reviewed and determined for program to be removed.</p> <p>DON and interdisciplinary team in collaboration with the medical director reviewed and revised as necessary the policies and procedures about assessment and use of catheters and toileting programs.</p> <p>DON or designee will provide education on 8/10/2015 for facility staff on appropriate assessment and use of catheters, toileting programs, glove use, and reporting changes to charge nurse.</p> <p>DON or designee will perform audits to ensure appropriate diagnoses justify an indwelling catheter, catheter care, glove use, and fluid input flow sheet completion for 4 weeks and monthly eleven more months.</p> <p>DON or designee will present findings at the monthly QAPI meetings for review.</p> | |

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| F 315 | <p>Continued From page 85</p> <p>Review of resident 9's 4/20/15 updated and revised care plan had no documentation related to the use of the Foley catheter. There was no documentation related to the recurrent urinary tract infections or to push fluids.</p> <p>Observation on 7/8/15 at 12:00 noon of certified nursing assistant (CNA) J assisting resident 9 with Foley catheter care revealed:</p> <ul style="list-style-type: none"> *She washed her hands in the resident's bathroom and put on gloves. *She transferred him from his wheelchair into the bed with the use of a stand-aide (mechanical lift that required the resident to be able to bear weight on his legs). *She washed her hands in the resident's sink and put on a new pair of gloves. *She obtained a washbasin from the resident's bathroom and filled it with water and a few drops of soap. *She pulled his foreskin (covering over penis) back. There was a large amount of white film under the penis with the skin being red under the foreskin. Both inner groins were reddened. *The resident verbalized discomfort several times while she was washing around and under the foreskin with a washcloth and drying the areas with a hand towel. *She washed her hands in the resident's bathroom while wearing the gloves she had used to wash his foreskin and penis. *She took the plastic container to empty his Foley catheter drainage bag. She did not use anything to wipe the tip of the drain tube when she unclamped it to empty the urine from tube into the container, or when she reconnected the end back to the catheter tubing. *She adjusted the height of the bed with the | F 315 | | |

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| F 315 | <p>Continued From page 86</p> <p>control on the head board and put his call light that was on the easy chair over to him. She continued to wear the same gloves she had used to provide the Foley catheter care and to empty the urine from his drainage bag.</p> <p>*She went into the resident's bathroom and removed one glove. She emptied the urine container into the toilet with her ungloved hand and flushed the toilet with the gloved hand.</p> <p>*She removed both gloves in the resident's bathroom and washed her hands.</p> <p>Interview on 7/8/15 at 12:15 p.m. with CNA J regarding the above observation revealed: *"I guess I should have changed my gloves." *Foley catheter care was usually done when a resident was gotten up for the day and at bedtime. *CNA K had gotten him ready for the day. She had not said anything to her about the resident being red and having discomfort under his foreskin and in the groins. *She would inform the nurse of the resident's redness as she knew there was a special powder that could be used.</p> <p>Interview on 7/8/15 at 12:30 p.m. with CNA K regarding resident 9's morning Foley catheter care revealed she: *Had done Foley catheter care on him that morning when she got him dressed for the day. *Had noticed some redness under the foreskin and in the groin areas "more pinkish." *Had put baby powder around the foreskin and in the groins. *Did not feel he was uncomfortable when she was washing and drying the areas. *Should have let the nurse on duty know about the redness in the areas.</p> | F 315 | | | |

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| F 315 | Continued From page 87 Interview on 7/8/15 at 12:50 p.m. with registered nurse L regarding resident 9 revealed: *She was not aware of the redness and irritation around his foreskin and groin areas. *CNA K should have informed her when she had gotten him up in the morning. *CNA J had informed her, and she had put some Nystatin (antifungal powder) powder on the areas. Interview on 7/8/15 at 3:00 p.m. with the dietary manager regarding resident 9's fluid intake revealed: *They tried to offer him at least 360 milliliters (ml) daily with meals. *She was unsure how much nursing offered him inbetween meals and if that fluid intake was documented anywhere. *According to his March 2015 through July 2015 dietary fluid intake records he usually accepted 80 ml to 180 ml each meal. Interview on 7/14/15 at 4:30 p.m. with the director of nursing regarding resident 9's Foley catheter care observation revealed: *CNA J should have removed her gloves and washed her hands after providing catheter care. She should not have washed her hands with her gloves on. *CNA K should have informed the nurse of his foreskin redness and groin irritation when she had assisted him with catheter care in the morning. *The physician's order to push fluids meant they encouraged extra fluids during the daytime. *They did not record any fluid intake that nursing offered him inbetween meals. *They were unable to state on any given day how much fluid intake he was offered, and how much | F 315 | | | |

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| F 315 | <p>Continued From page 88 fluid intake he accepted.</p> <p>Review of the providr's undated Serving of Drinking Water policy revealed: **"Purpose is to encourage an adequate fluid intake." **"Record amount taken on intake record if required." **"Encourage fluid intake." Surveyor: 33265 2. Interview on 7/9/15 at 10:40 a.m. with resident 6 regarding catheter care revealed: *Catheter care was not completed every shift. **"The CNAs (certified nursing assistants) do catheter care after I have a bowel movement. I have a bowel movement every two or three days. I will have them call you if they do it while you are here." *Certified nursing assistants (CNA) B and C entered the room and were asked to notify the surveyor when they were going to do any cares for resident 6. -There had been no call to the resident's room to observe cares provided during the remainder of the survey.</p> <p>Interview and review of resident 6' medical record on 7/13/15 at 3:20 p.m. with the director of nursing (DON) revealed: *The resident had an indwelling Foley catheter. *She had two urinary track infections (UTI) within the last six months. -Those were on 1/8/15 and 4/22/15. *There was a 1/9/15 physician's order to change the catheter monthly on the 11th. *The catheter was found pulled out on 6/4/15 with no documentation how it had happened. *The order to replace the catheter monthly was discontinued on 6/6/15.</p> | F 315 | | | |

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| F 315 | <p>Continued From page 89</p> <p>*The catheter was replaced on 6/14/15. -There was no documentation clarifying if the catheter should be replaced monthly or not following its re-insertion.</p> <p>*The 4/21/15 care plan documented the Foley catheter was in place to promote skin healing and integrity. - Catheter care was not documented on the care plan.</p> <p>*DON stated catheter care was to have been done each shift by the CNAs.</p> <p>*The DON had no comment concerning the resident's interview that stated catheter care was not done each shift but only after a bowel movement.</p> <p>*Catheter care was checked as completed in the electronic medical record on each of the three shifts since 6/30/15.</p> <p>*No medical diagnosis for the use of an indwelling Foley catheter was found in the documentation.</p> <p>*The DON agreed there was no medical diagnosis for the use of an indwelling Foley catheter.</p> <p>Surveyor 22452 Review of the provider's 6/3/15 Catheter Care, Indwelling Catheter policy revealed: **"Purpose is to prevent infection and reduce irritation." **"Assessment guidelines may include, but are not limited to: -Color, consistency, and amount of urine. -Condition of skin at site of insertion. -Pain, burning, discomfort. -Level of activity. -Nutritional intake. -Hydration and fluid balance status." **"Hand washing remains the single most important step in preventing the spread of</p> | F 315 | | | |

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| F 315 | <p>Continued From page 90</p> <p>infection." *"Enter the catheter care as an approach under the appropriate underlying problem on the resident's care plan." *"Identifying the underlying problem will assist the nursing staff to develop an individualized care plan." Surveyor: 34030 B. Based on interview, record review, and policy review, the provider failed to have an individualized toileting program for three of three sampled residents (3, 5, and 12). Findings include:</p> <p>1. Review of resident 3's 4/28/15 Minimum Data Set (MDS) assessment revealed he was on a toileting program.</p> <p>Review of resident 3's 9/19/14 care plan with a hand written reviewed and updated date of 6/2/15 revealed: *"Staff will assist him to the bathroom upon rising, before and after meals, before bed, every 2-3 hours through the night, and PRN [as needed]."</p> <p>Review of resident 3's medical records revealed: *An assessment had not been done to determine when he needed to use the bathroom. *There was not an individualized toileting program.</p> <p>2. Review of resident 5's 2/11/15 annual and 5/7/15 quarterly MDS assessment revealed he was on a toileting program without improvement.</p> <p>Review of resident 5's 8/30/14 care plan revealed the same toileting program as for resident 3.</p> <p>Review of resident 5's medical records revealed:</p> | F 315 | | |

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| F 315 | <p>Continued From page 91</p> <p>*An assessment had not been done to determine when he needed to use the bathroom.</p> <p>*There was not an individualized toileting program.</p> <p>3. Review of resident 12's 4/20/15 initial MDS assessment revealed she was on a toileting program.</p> <p>Review of resident 12's 4/30/15 care plan revealed the same toileting program as the above other two residents.</p> <p>Review of resident 12's medical records revealed: *An assessment had not been done to determine when she needed to use the bathroom. *There was not an individualized toileting program.</p> <p>Surveyor: 32335 Interview on 7/8/15 at 9:20 a.m. with the Minimum Data Set (MDS) assessment coordinator revealed: *She oversaw the restorative program which included the bowel and bladder toileting program. *They had not completed individualized resident bowel and bladder assessments to determine resident needs. *The resident toileting programs had not been individualized.</p> <p>Surveyor: 34030 Review of the provider's undated Bladder Management Program revealed: *Assessment guidelines to include: -A three day bowel and bladder study upon admission to determine continence (ability to hold urine or stool). -Levels of mobility and comprehension.</p> | F 315 | | | |

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| F 315 | Continued From page 92 -Type and cause of incontinence. *Intervention strategies to include: -"Scheduled toileting and habit training." -"Develop a toileting schedule as close to the resident's routine as possible." -"Encourage the resident to continue the program until continence is achieved." -"If incontinence persists identify possible causes and type of incontinence." **"A scheduled toileting program should be individualized and based on a voiding diary." | F 315 | | | |
| F 323 SS=H | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to: *Assess, investigate, and follow interventions to prevent falls with injuries for three of six sampled residents (1, 2, and 9). *Ensure the appropriate use and placement of the lift sling straps during transfer for one of one observed resident (6). *Identify and address staff training needs for the safe and appropriate use of all facility mechanical lifts. Findings include: | F 323 | F323 Care plans for Resident's 1,2, 9 were reviewed and updated to ensure interventions were included to prevent falls. Care plans for all other resident's at risk for falls were reviewed and updated to ensure interventions were included to prevent falls. <i>*and all other direct care staff</i> CNA B and G will be educated on 8/10/2015 on proper usage of mechanical Hoyer lift transfers for Resident 6 and all other residents who require mechanical Hoyer lift transfers. Administrator, DON, and interdisciplinary team in collaboration with the medical director reviewed and revised as necessary the policies and procedures about accident/injury assessment, investigation, evaluating, and implementing or changing interventions. | 8/12/2015 <i>and 500H/JJ</i> | |

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| F 323 | Continued From page 93 1 Review of resident 9's 3/20/15 through 5/17/15 nursing progress notes revealed: *3/20/15 at 6:07 p.m., "Resident was found lying on the left side on floor beside bed. Resident reports attempted to transfer self to bed from wheelchair. Resident denies any pain or discomfort and denies hitting head. There are multiple bruises to left arm and one on left side of abdomen but they all look to be old. Will continue to monitor." *5/5/15 at 4:57 p.m., "Resident found on the floor at 4:40 p.m. Per certified nursing assistant [CNA] resident had a visitor and had been left alone in his room with the door closed after she left. CNA was trying to watch and see when the family left to take resident out to the dining room. Resident hit the back of his head on the right side and has a bruise/raised area. Called son and relayed above. Asked him to pass on to family not to leave the resident alone in his room." *5/17/15 at 9:50 a.m., "Resident was found sitting on floor beside his bed. Resident reports attempting to transfer self from wheelchair to bed. No injury noted and resident denies hitting head or any pain. Will continue to monitor." Review of resident 9's 3/20/15 through 5/17/15 Fall Investigation Worksheets revealed: *3/20/15, "After supper resident wheeled self back to room and attempted to self transfer to bed from wheelchair. -"Resident did not call for assist." -"Cause of fall was weakness." -Fall "unwitnessed." -Care plan updated was left blank. *5/5/15, "Trying to put himself to bed." -"Cause of fall was weakness." -Did resident call for help or call light within reach | F 323 | DON or designee will provide education on 8/10/2015 for facility staff on appropriate accident/injury assessment, investigation, evaluating, and implementing or changing interventions.  DON or designee will present findings at the monthly QAPI meetings for review. <i>DON or designee will perform audits to:</i> • ensure identified interventions are added to care plans for those identified at risk for falls or have a fall, will be completed 10-12 at a time, • observe two transfers with mechanical Hoyer lift for appropriate technique, • ensure two falls are thoroughly investigated. <i>All audits will be completed weekly for four weeks, then monthly for eleven months.</i> <i>DW/sooth/JJ</i> | |

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| F 323 | <p>Continued From page 94 was left blank.</p> <ul style="list-style-type: none"> -Fall "unwitnessed." -Care plan updated was checked "yes." *5/17/15, "Transfer from wheelchair to bed." -"Resident did not call for assist." -"Cause of fall was weakness." -Fall "unwitnessed." -Care plan updated was checked "yes." <p>Review of resident 9's 4/20/15 reviewed and updated care plan revealed:</p> <ul style="list-style-type: none"> ***"At risk for falls." ***"Interventions will be utilized to reduce the risk of falls." ***"Has severe cognitive [memory] impairment." ***"Decreased safety awareness, impaired gait [walking], and weakness putting him at risk for falls." ***"He wears a personal alarm to alert staff when he tries to transfer self as he does not always remember to ask for assistance." *There was no documentation regarding his recent falls or any interventions to not leave him unattended in his room in his wheelchair. <p>Interview on 7/14/15 at 9:45 a.m. with the director of nursing regarding resident 9 revealed:</p> <ul style="list-style-type: none"> *She confirmed there was no documentation on his care plan regarding the above three falls when he was attempting to transfer himself from his wheelchair to bed. *He no longer had a personal alarm on. They had discontinued all the TABs (alarm attached to resident that would sound when a resident attempted to transfer self) in June 2015. *He was not able to use the call light or consistently verbalize his needs to the staff due to his severe memory impairment. <p>Surveyor: 35625</p> | F 323 | | |
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| F 323 | <p>Continued From page 95</p> <p>2. Review of resident 2's 6/9/15 fall investigation worksheet and nursing progress note revealed: **"He was agitated and yelling out after his wife left at approximately 1:15 p.m." **"Staff transferred the resident to bed at 1:25 p.m. and left the room." **"He was found on floor beside his bed at 1:35 p.m. -Had hit his forehead on the bedside stand." -"Physician was contacted with results of the vitals [blood pressure, heart rate, breaths per minute, respirations, and temperature] and neurological [hand grasps, memory, pain, and the size of pupils in the eyes]assessment. No new orders were obtained." **"A fall scene [looks at the fall in detail] investigation report was initiated by staff." -"The cause was determined to be agitation following a family member leaving." -"Proposed intervention was to call the physician to schedule Haldol [a mood and behavior altering medication] around the lunch hour when the family was present." -No non-pharmacological interventions were documented or appear to have been implemented.</p> <p>Review of resident 2's 6/30/15 reviewed and updated care plan revealed: **"Increased risk for falls, personal alarm to alert staff when he gets up." *No changes had been made to the care plan following the 6/9/15 fall.</p> <p>Interview on 7/8/15 at 8:15 a.m. with the director of nursing (DON) and social worker regarding resident 2 revealed: *They had discontinued the use of personal alarms (alarm attached to residents' body that</p> | F 323 | | |

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| F 323 | <p>Continued From page 96</p> <p>would go off when the resident attempted to self transfer) in June 2015 for all residents.</p> <p>*They had not documented any non-homological interventions other than administering the Haldol to relieve his mental distress.</p> <p>*They were unable to provide the rationale for the resident being left alone and unattended during a period of increased agitation.</p> <p>*There was no documentation regarding additional investigation and interventions that had been put into place to prevent future falls.</p> <p>Review of resident 2's 6/9/15 medication administration record revealed Haldol was administered at 4:57 p.m. for yelling out and agitation. There was documentation at 7:38 p.m. the Haldol had been "effective."</p> <p>Surveyor: 32335</p> <p>3. Review of resident 1's medical record revealed:</p> <p>*On 9/20/14 he had an unwitnessed fall with no injury.</p> <p>*He had been walking to the bathroom and lost his balance.</p> <p>*Interventions marked on the fall short term care plan were:</p> <p>- "Monitor and report changes in anxiety, sleep patterns, behaviors, or mood."</p> <p>- "Assess blood sugar fluctuations."</p> <p>- "Promote adequate hydration."</p> <p>- "Increase staff assistance."</p> <p>- "Monitor and remind resident appropriate use of assistive devices, keep within easy reach."</p> <p>- "Call light within reach and secured."</p> <p>*On 10/14/14 he had an unwitnessed fall with no injury.</p> <p>- He had been sitting in his recliner and went to stand up.</p> | F 323 | | |

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| F 323 | <p>Continued From page 97</p> <p>-He had not been wearing gripper socks. *Interventions marked on the fall short term care plan were: -"Appropriate footwear." -"Non slip mat to wheelchair." *On 10/31/14 he had an unwitnessed fall with minor injury. -He had slid out of his recliner. -He had not been wearing gripper socks. *Interventions marked on the fall short term care plan were: -"Pain Management." -"Assess blood sugar fluctuations." -"Promote adequate hydration." -"Keep bed in lowest position while in bed." -"Clear path to the bathroom." -"Call light within reach and secured." -"Appropriate footwear." *On 12/18/14 he had an witnessed fall with no injury. -He had attempted to get up from his wheelchair and lost his balance. *Interventions marked on the fall short term care plan were: -"Assess blood sugar fluctuations." -"Promote adequate hydration." -"Low vision precautions." -"Corrective lenses." -"Increase staff assistance." -"Increased bathroom safety." -"Promote wheelchair safety." -"Check brakes and instruct patient on use." -"Monitor and remind resident appropriate use of assistive devices, keep within easy reach." -"Remind, monitor residents ability to maneuver change in flooring." -"Clear path to the bathroom." -"Call light within reach and secured." -"Appropriate footwear."</p> | F 323 | | | |

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| F 323 | Continued From page 98 -"Increase assistance or surveillance." -"Frequent rest periods." -"Increase activity involvement." *On 1/25/15 he had an unwitnessed fall with major injury. -He had been found on floor. *Interventions marked on the fall short term care plan were: -"Low vision precautions." -"Clear path to the bathroom." -"Call light within reach and secured." -"Increase assistance or surveillance." *On 2/15/15 he had an witnessed fall with no injury. -He went to stand up out of his wheelchair and lost his balance. *Interventions marked on the fall short term care plan were: -"Pain Management." -"Promote adequate hydration." -"Low vision precautions." -"Corrective lenses." -"Increase staff assistance." -"Increased bathroom safety." -"Check brakes and instruct patient on use." -"Monitor and remind resident appropriate use of assistive devices, keep within easy reach." -"Remind, monitor residents ability to maneuver change in flooring." -"Clear path to the bathroom." -"Call light within reach and secured." -"Toileting schedule." -"Appropriate footwear." -"Increase assistance or surveillance." -"Frequent rest periods." -"Increase activity involvement." *On 3/24/15 he had an witnessed fall with major injury. -He stood up from table in dining room and lost | F 323 | | | |

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| F 323 | <p>Continued From page 99</p> <p>his balance.</p> <p>*Interventions marked on the fall short term care plan were:</p> <ul style="list-style-type: none"> - "Assess blood sugar fluctuations." - "Promote adequate hydration." - "Increase staff assistance." - "Monitor and remind resident appropriate use of assistive devices, keep within easy reach." - "Increase activity involvement." <p>*On 5/16/15 he had an witnessed fall with no injury.</p> <p>- He had been sitting in his wheelchair and got up to sit in recliner, and he lost his balance.</p> <p>*Interventions marked on the fall short term care plan were:</p> <ul style="list-style-type: none"> - "Assess blood sugar fluctuations." - "Increase staff assistance." - "Promote wheelchair safety." - "Check brakes and instruct patient on use." - "Monitor and remind resident appropriate use of assistive devices, keep within easy reach." - "Call light within reach and secured." - "Restorative program." - "Assess for PT/OT [physical therapy/occupational therapy] possibility." - "Increase assistance or surveillance." - "Personal or pressure change alarm." - "Increase activity involvement." <p>*None of the above interventions had been transferred to the care plan.</p> <p>*There was no documentation the above falls had been investigated thoroughly.</p> <p>*There was no documentation the interventions had been monitored to determine if they had been effective.</p> <p>Review of resident 1's 4/8/15 care plan revealed he was at an "Increased risk for falls d/t [due to] antidepressant medication use, and decreased</p> | F 323 | | |

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| F 323 | <p>Continued From page 100 safety awareness. Staff to assist with transfers and toileting."</p> <p>Review of resident 1's 6/20/14 admission Minimum Data Set (MDS) assessment revealed he required limited assistance of one staff person to transfer from one place to another and to walk.</p> <p>Interview on 7/7/15 at 3:15 p.m. with the DON revealed the fall interventions should have been included on the care plan. The investigations had not been completed thoroughly. There was no documentation to support the interventions had been monitored for their effectiveness.</p> <p>4. Review of the provider's 6/4/15 fall policy revealed: *The resident care plan should have been revised and updated. *The fall scene investigation report should have been completed. *All incidents were reviewed by the DON and administrator. *The falls committee should have reviewed all falls.</p> <p>Surveyor: 33265</p> <p>5. Observation on 7/9/15 at 10:45 a.m. of certified nursing assistants (CNA) B and C using a mechanical lift (type of equipment used to move a resident from one place to another) to transfer resident 6 from a chair to her bed revealed the incorrect placement of straps on the lift sling.</p> <p>6. Review of resident 6's medical record revealed resident had slid out of a mechanical lift sling due to improper placement of the sling under the resident.</p> | F 323 | | |

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| F 323 | Continued From page 101 | F 323 | | | |
| F 329 SS=D | Refer to F 224, findings 2 and 3. 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Surveyor: 35625 Based on record review and interview, the provider failed to ensure one of one sampled resident (2) had an appropriate diagnosis and | F 329 | F329 Resident 2's physician was notified to obtain appropriate medical diagnosis for use of antipsychotic medications. All other residents who receive antipsychotic medications were reviewed to ensure appropriate medical diagnosis was utilized. DON in collaboration with the pharmacist and the medical director reviewed and revised as necessary the policy and procedure about appropriate assessment for use and non-pharmacological interventions for antipsychotic medications. DON or designee will provide education on 8/10/2015 for facility staff regarding utilization and documentation of non-pharmacological interventions including but not limited to pain management, bowel management, and activity interventions for anxiety and agitation. All new employees will be provided education with orientation process. DON or designee will perform audits to ensure appropriate medical diagnoses are obtained for antipsychotic medication usage and non-pharmacological interventions are carried out for four weeks and monthly for two more months. DON or designee will present findings at the monthly QAPI meetings for review. | 8/12/2015 | |

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| F 329 | <p>Continued From page 102</p> <p>non-pharmacological interventions had been used prior to an as needed (PRN) medication Haldol (a mood and behavior altering medication). Findings include:</p> <p>1. Review of resident 2's complete medical record revealed: *A 12/6/12 admission date. *Diagnoses of: glaucoma (increased eye pressure), vascular dementia (memory loss), gout (recurrent arthritis), hypertension (high blood pressure), legal blindness, macular degeneration (loss of vision), history of vertigo (dizziness), history of heel ulcers (open wounds).</p> <p>Review of resident 2's behavioral health hospitalization record from 9/17/13 through 10/4/13 revealed: *The medication Haldol 5 milligrams (mg) as needed twice daily was initiated for agitation/anxiety/behavioral changes. *He was diagnosed with vascular dementia and delirium (acute confusion) NOS (not otherwise specified)-pain related. *They recommended to consider treating his pain, as agitation might be the resident's way of expressing pain. *Follow-up medication management was to be completed by the resident's primary care physician.</p> <p>Review of resident 2's 6/19/14 pharmacy consultation note revealed: *The resident was prescribed Haldol 5 mg twice daily as needed. *He had only been using the medication a "handful" of times each month. *A recommendation was made to treat anxiety with as needed (PRN) lorazepam (a medication</p> | F 329 | | | |

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| F 329 | <p>Continued From page 103 to reduce anxiety).</p> <p>Review of resident 2's 6/26/14 through 7/25/14 nursing progress notes revealed: *A physician's order had been obtained to discontinue his PRN Haldol and change the medication to lorazepam 0.5 mg every six hours PRN per pharmacy recommendations. *The lorazepam was administered fourteen times for the resident yelling or showing unspecified signs of anxiety. -It was noted to be effective after twelve of the medication doses. -Music was shown to be helpful after one administration of lorazepam. *On 7/20/14 at 10:21 p.m. "Placed call to on-call physician related to PRN ativan [lorazepam] not being effective. One-time order received. Informed a fascimile (fax) was sent to his office asking to change the PRN ativan [lorazepam] back to PRN Haldol."</p> <p>Review of resident 2's 7/24/14 physician's order revealed: *Lorazepam PRN was to be discontinued. *Haldol 5 mg twice daily as needed for agitation/anxiety was ordered. **"Ativan [lorazepam] was tried and found to be less effective."</p> <p>Review of resident 2's 3/10/15 consultant pharmacist communication revealed: *A recommendation for a gradual dose reduction of Haldol to 2.5 mg twice daily PRN. *The physician agreed, and an order was obtained for Haldol 2.5 mg twice daily PRN.</p> <p>Review of resident 2's 4/1/15 through 7/7/15 medication administration record revealed Haldol</p> | F 329 | | |

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| F 329 | <p>Continued From page 104</p> <p>was administered:</p> <ul style="list-style-type: none"> *Twelve times from 4/1/15 through 4/30/15. *Eleven times from 5/1/15 through 5/30/15. *Seventeen times from 6/1/15 through 6/30/15. *One time from 7/1/15 through 7/7/15. <p>Review of resident 2's 4/1/15 through 7/7/15 nursing progress notes revealed:</p> <ul style="list-style-type: none"> *There was no documentation of any non-pharmalogical interventions attempted prior to the administration of the Haldol. *The resident had been treated with antibiotics for a urinary tract infection twice in April and once in June. *Resident had difficulty with bowel movements and required the use of PRN laxatives (medications to promote a bowel movement). <p>Interview on 7/8/15 at 8:15 a.m. with the director of nursing and the social worker regarding resident 2 revealed:</p> <ul style="list-style-type: none"> *Haldol was used twice a day as needed (PRN) for agitation/anxiety. *Use of the Haldol had increased over the last three to four months. *There was no documentation the physician had been notified of the increased use of the Haldol. *They had not assessed for pain which was a chronic issue or to treat his frequent constipation. *The resident's agitation consisted of yelling out for family members after they had visited him and for farming. *There was no documentation of non-pharmacological interventions that had been attempted when he hollered out. *The nursing staff had discussed administering Haldol around noon. His wife usually came and assisted him daily with his noon meal. *They had not been documenting any adverse | F 329 | | |

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| F 329 | Continued From page 105 effects from the administration of the Haldol. Interview on 7/13/15 at 12:00 noon with the activities director regarding resident 2 revealed there were no interventions put into place for episodes of increased agitation. Review of the American Society of Consultant Pharmacists Board of Directors, June 7, 2011, Policy Statement, Use of Antipsychotic Medications in Nursing Facility Resident's revealed: "The use of antipsychotics in nursing facility residents should include: -An appropriate indication for use. -A specific and documented goal of therapy. -Ongoing monitoring of the resident to evaluate effectiveness in achieving the therapy goal and the development or presence of adverse effects from the medication. -Use of the medication only for the duration needed, and at the lowest effective dose. | F 329 | | | |
| F 371 SS=D | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: | F 371 | F371 Floor in the dry goods storage room in the kitchen and under the garbage disposal was observed to ensure sanitary conditions were maintained. Appropriate cleaning and maintenance were performed to such areas of the floor. Refrigerator temperature logs were reviewed to ensure temperature was maintained at 41 degrees Fahrenheit or below and supporting documentation was logged. | 8/12/2015 | |

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| F 371 | Continued From page 106 Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to: *Ensure sanitary conditions were maintained for the floors in the dry goods storage room in the kitchen and under the garbage disposal. *Maintain documentation the refrigerator temperatures were 41 degrees Fahrenheit (F) or below for one of two refrigerators (double refrigerator) in the kitchen. Findings include: 1. Observation on 7/7/15 from 8:10 a.m. through 3:05 p.m. and on 7/8/15 at 8:40 a.m. in the kitchen in the dry goods storage room and the floor under the garbage disposal revealed the following: *The floor under the shelving units in the storage room had many visible tan, black, and brown spots and debris. *The floor between the freezer units and the door in the dry goods storage area had the same as the above. *There was a large piece of chipped tile that collected dirt and debris under the garbage disposal in the kitchen. Interview on 7/8/15 at 3:10 p.m. with the dietary manager (DM) regarding the above floors revealed: *The floors in the storage room and the kitchen were to have been mopped every night. *One of the day staff came in once a week in the evening and did deep cleaning in the kitchen. *The 4:30 p.m. to 8:00 p.m. shift was responsible to mop the floors the other nights of the week. The cook was there until 6:30 p.m. After 6:30 p.m. there was no supervision of the staff who were responsible to mop the floors. | F 371 | Dietary Manager or designee will perform audits to ensure sanitary conditions are maintained on the floor in the dry goods storage area and underneath garbage disposal for four weeks and monthly for two more months. Dietary Manager or designee will perform audits to ensure temperature logs for the refrigerators are complete and accurate for four weeks and monthly for two more months. Dietary Manager or designee will present findings at the monthly QAPI meetings for review. | | |

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| F 371 | <p>Continued From page 107</p> <p>*The cleaning schedule had not been followed as there were multiple blank areas on the cleaning schedule. They usually just did the cleaning and did not document it on the cleaning schedule.</p> <p>*No matter how much the floor in the storage room was cleaned, they were unable to remove the large amounts of stains that were embedded (worked into) the flooring.</p> <p>*She confirmed the large chip under the garbage disposal was an uncleanable surface.</p> <p>*She had made numerous requests the past year to administration regarding the condition of the floors.</p> <p>Interview on 7/8/15 at 4:45 p.m. with the environmental director regarding the above floors revealed:</p> <p>*He had buffed the storage room floor about three times the past year, but he had not documented when he had done that.</p> <p>*As soon as he was done buffing the floor it would return to it's previous condition after the delivery truck brought in their food supplies.</p> <p>*The storage room floor could be stripped and rewaxed, but it was not a reasonable investment for that floor.</p> <p>*There was no way to keep the storage room floor clean unless the whole floor was replaced. They had multiple resident care areas that needed new flooring before the storage room floor.</p> <p>Review of the provider's May 2012 Sanitation and Safety Department Cleaning policy revealed:</p> <p>*The dietary department was to have been maintained in a sanitary condition.</p> <p>*The director of dietary services was responsible for developing cleaning procedures.</p> | F 371 | | | |

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| F 371 | <p>Continued From page 108</p> <p>Review of the provider's May 2012 Sanitation and Safety Walls, Floors, and Ceilings policy revealed: *Cleaning floors was to have been completed as follows: -Sweep well. -Wash with hot water and no-suds cleaning solution. -Rinse well using mop. -Remove as much water as possible. -Let air dry. -Wipe with sanitizer. -Permit to air dry. -Place "Wet floor" signs to warn others of potential danger.</p> <p>Review of the provider's May 2012 Sanitation and Safety Cleaning Schedule revealed the dry store room floor was to have been thoroughly cleaned weekly.</p> <p>2. Observation on 7/7/15 from 8:10 a.m. through 4:00 p.m. and on 7/8/15 at 8:30 a.m. of the double refrigerator in the kitchen revealed: *There was a large amount of ice build-up around the condensing coil. *The thermometer in the refrigerator was at 40 degrees F. *The July 2015 refrigerator monitoring sheet hanging on the wall beside the refrigerator had no documentation of the refrigerator temperatures for 7/3/15, 7/4/15, 7/5/15, or 7/6/15.</p> <p>Interview on 7/8/15 at 3:30 p.m. with the DM regarding the refrigerator temperatures revealed: *She knew they had someone recently check the ice build-up in the refrigerator, and they had said the refrigerator was operating okay. *She confirmed without the staff documenting the</p> | F 371 | | | |

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| F 371 | <p>Continued From page 109</p> <p>daily temperatures of the refrigerator, she was not able to state the temperature of the refrigerator was consistently 41 degrees F or less.</p> <p>*The staff documenting the daily temperatures had been a problem, and she had talked to the dietary staf about that issue. The day (preparation (prep) cook was the person responsible to check the refrigerator temperature daily and document the reading on the temperature monitoring sheet.</p> <p>*She confirmed the April 2015 through June 2015 refrigerator daily temperature records also had multiple blank areas where the temperature had not been recorded.</p> <p>*It was her responsibility to monitor the staff documenting the refrigerator temperatures.</p> <p>Interview on 7/8/15 at 4:55 p.m. with the environmental director regarding the refrigerator revealed:</p> <p>*He had a refrigeration company come and check the refrigerator due to the large amount of ice build-up on the condensing coil. He had not documented when they had checked the refrigerator, he thought maybe about two weeks ago.</p> <p>*Due to the age of the refrigerator they did not have the appropriate door seal, and the company had tried to sell them a new refrigerator.</p> <p>*The company was supposed to get back to him with a bid for a new refrigerator door or a generic seal, and they had not done that yet. He had called them back and left another message. He had not documented either date he had talked to the company.</p> <p>*He had put extra weather seal around the door as a temporary solution.</p> <p>*As far as he knew the refrigerator temperatures had been within the appropriate range.</p> <p>*It was dietary's responsibility to let him know if</p> | F 371 | | |
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| F 371 | Continued From page 110 the temperature of the refrigerator was not 41 degrees F or less. The environmental director provided the following typed note to the surveyor on 7/9/15 at 10:00 a.m.: **"Service calls on 6/16/15 and 6/18/15." **"Cooler is functioning properly, technician suggested a new door seal." **"The manufacturer for that seal is no longer in business." **"The company will have a quote to me by 7/14/15." | F 371 | | | |
| F 425 SS=D | 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain, them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. | F 425 | F425 Lortab bottle was sent to pharmacy and repackaged in bottle for facility to accurately secure and reconcile. Bottle was placed in secure lock box and reconciled on narcotic flow sheet. Fentanyl patches will be disposed in designated sharps container located in locked medication room <i>*per pharmacy consultant recommendation and policy. DW/5000H/JJ</i> Control Substance Policy and Discarding and Destroying Medications Policy were reviewed and updated to ensure accuracy. Appropriate staff educated on policy update. DON or designee will perform audits <i>*on all controlled substances</i> to ensure controlled substances are accurately <i>DW/5000H/JJ</i> secure, reconciled, and disposed of for four weeks and monthly for two more months. DON or designee will present findings at the monthly QAPI meetings for review. | 8/12/2015 | |

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| F 425 | <p>Continued From page 111</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030</p> <p>Based on observation, interview, record review, and policy review, the provider failed to:</p> <ul style="list-style-type: none"> *Adequately secure and reconcile (account for the amount used) a bottle of liquid Lortab (a narcotic pain medication) located in one of three medication carts. *Adequately secure used Fentanyl patches (a narcotic pain medication) from unauthorized access. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Observation on 7/8/15 at 4:30 p.m. of a medication cart revealed: <ul style="list-style-type: none"> *Three large bottles of liquid Lortab located within the scheduled medication area of the medication cart. -Lortab is a schedule II (two) narcotic (highly addictive and a drug diversion [theft] risk). -Those bottles were for the same resident. -One bottle was nearly empty and the other two were full. -The dose on the label was 30 milliliters daily. <ul style="list-style-type: none"> *There were no markings on the outside of the bottles to show the amount of medication inside. *There was no date on the bottle that was nearly empty to show when it had been opened. *They were not keeping track of the amount or times when it was used compared to the amount left in the bottle. *The bottles of Lortab were not separate from the non-narcotic medication in the cart, and because it was a narcotic medication it should have been in a locked area. <p>Interview at the same time with registered nurse (RN) A revealed they (the nurses) had not thought</p> | F 425 | | |

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| F 425 | <p>Continued From page 112 reconciliation needed to be done as it was a scheduled medication.</p> <p>Interview a few minutes later with the director of nursing (DON) regarding the bottle of Lortab revealed she had not been aware of the need for reconciliation of the medication nor for securing it.</p> <p>Review of the provider's December 2012 Controlled Substances policy revealed: *Upon receipt of a schedule II drug a count must be done and then "an individualized resident controlled substance record must be made for each resident that must contain:....time and method of administration and signature of person receiving medication and signature of nurse administering medication." **"Controlled substances [schedule two] must be stored in the medication room in a locked container, separate from containers for any non-controlled medications."</p> <p>2. Interview on 7/7/15 at 2:15 p.m. with RN H during medication pass revealed: *Used Fentanyl patches (a narcotic pain medication) were placed into the sharpes container (a container attached to the medication cart). *She stated when those containers were full they were placed in a box located in the boiler room downstairs. The containers were held there until a contracted company would pick them up for disposal. *The door to the boiler room was locked. The key to that room was located outside of the door. *The boiler room was accessible to all staff and therefore so were the used Fentanyl patches. *RN H had not realized this was not secure. *Used Fentanyl patches are considered to have a</p> | F 425 | | | |

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| F 425 | Continued From page 113 potential for drug diversion. Interview on 7/8/15 at 4:30 p.m. with the DON revealed she agreed the Fentanyl patches had not been secured from unauthorized access. Review of the provider's April 2013 Discarding and Destroying Medications policy revealed nothing specific regarding the security of used narcotic patches such as Fentanyl except "Staff shall contact the provider pharmacy if they are unsure of proper disposal methods for a medication." | F 425 | | |
| F 441 SS=F | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (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 | F 441 | F441 Pathogenic findings have been added to infection control investigations. Whirlpool cleaning policy and procedure will be amended to reflect the manufacturer information provided. This will include the amount of water to be used in the whirlpool, and the exact amount of cleaner /disinfectant solution to be added. A time piece will be added in the room to ensure that the contact time can be observed. Wound nurse educated on 7/30/2015 on proper dressing change policy. <i>*All other nurse staff responsible for dressing change will receive education on or before 8/10/15.</i> Administrator, DON, governing board, and interdisciplinary team reviewed and revised as necessary the policy and procedure about infection prevention and control. | 8/12/2015 <i>aw/saath/jj</i> |

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| F 441 | <p>Continued From page 114</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, procedure review, policy review, and manufacturer's information review, the provider failed to:</p> <ul style="list-style-type: none"> *Maintain an effective infection control program. *Clean and disinfect two of two residents' use whirlpool tubs and one of one residents' shower area. *Use appropriate hand hygiene during resident care for two of two sampled residents (1 and 9). <p>Findings include:</p> <p>1. Review of the provider's 1/1/15 through 6/30/15 Infection Report revealed no pathogens (germs) had been identified on resident infections.</p> <p>Interview on 7/8/15 at 4:20 p.m. with the infection control nurse and the director of nursing (DON) revealed they:</p> <ul style="list-style-type: none"> *Tracked the resident and the antibiotic given (if any), but they did not track the pathogen causing | F 441 | <p>DON or designee will provide education on 8/10/2015 on appropriate infection prevention and control, hand washing, hand hygiene, and glove use. All new employees will be provided education with orientation process.</p> <div style="background-color: black; width: 100%; height: 80px; margin: 10px 0;"></div> <p>DON or designee will present findings at the monthly QAPI meetings for review.</p> <p><i>DON or designee will perform audits to:</i></p> <ul style="list-style-type: none"> • ensure pathogenic findings have been included for report tracking in infection control program, • observe two staff for proper whirlpool cleaning and disinfection, • observe and ensure two staff provides appropriate Foley catheter care, • observe and ensure two staff completes appropriate hand washing, hand hygiene, and or glove use for the assigned task. <p><i>All audits will be completed weekly for four weeks, then monthly for five months, then until directed otherwise by the QAPI committee. aw/sap/H/JJ</i></p> | |

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| F 441 | <p>Continued From page 115</p> <p>the infection.</p> <p>*Were aware of the current multiple repeat urinary tract infections among the residents but had done no audits to find out the cause and to follow through with the information.</p> <p>*Brought that information to quality assurance performance improvement meetings (QAPI), but they did not establish any goals.</p> <p>-The medical director did not attend QAPI/infection control meetings but was provided with the information.</p> <p>*Did infection control training for staff but did not follow-up on the effectiveness of that training.</p> <p>Interview on 7/9/15 at 11:35 a.m. with the provider's medical director revealed he did not follow-up on infections within the facility except those "with his own residents" or offer suggestions to the infection control committee.</p> <p>Review of the provider's 6/4/15 Infection Control Guidelines revealed "Infection control nurse monitors infections and reviews diagnostics, treatment, and follow up. Nurse identifies trends to identify cause. DON presents data at monthly QAPI meeting."</p> <p>Surveyor: 33265</p> <p>2. Observation of and interview on 7/8/15 at 10:05 a.m. of the cleaning of the shower area in the Rising Sun wing with certified nursing assistant (CNA) C revealed she:</p> <p>*Had not worn protective gloves.</p> <p>*Had not used a scrub brush on the shower chair or the other surfaces.</p> <p>*Sprayed shower chair and shower area with Betco AF79 disinfectant.</p> <p>*Stated she left the disinfectant on the surfaces "about ten minutes." There was no clock in the</p> | F 441 | | | |

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| F 441 | <p>Continued From page 116</p> <p>room for timing the disinfectant on the surfaces. *Stated she did not "have a watch." *Rinsed off the shower chair and the immediate area with water from the shower.</p> <p>Review of manufacturer's undated instructions for the Betco AF79 revealed the surfaces should have been wiped dry with a cloth, sponge or mop, or allowed to air dry.</p> <p>3. Observation and interview with surveyor 34030 and CNA C on 7/8/15 at 10:20 a.m. of the cleaning of the whirlpool tub in the Happy Trails wing by CNA D revealed she: *Had not worn protective gloves. *Had not utilized a scrub brush on the shower chair or other surfaces. *Stated the Betco AF79 was a "one step disinfectant and cleaner." *Sprayed all surfaces with the Betco AF79. *Waited ten minutes. When asked what clock she went by she shrugged her shoulders. -No clock was in the room to tell the time. She had not been wearing a watch. *Stated "you don't have to rinse off." *At the end of the day they utilized Virex II 256 One-Step Disinfectant Cleaner and Deodorant. -The lower well in the tub was filled one-half full, just beyond the agitator. She did not know how much water that was in gallons. -They put one water cup (they used the disposable cups by the water fountain) of Virex into the water in the well and started the whirlpool jets. She did not know the ounces of the cup that was used to measure the Virex. -They let that "run for a few minutes." -Then let the water and Virex drain out. -There was no rinsing of the whirlpool jets following the disinfection with Virex.</p> | F 441 | | |

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| F 441 | <p>Continued From page 117</p> <p>*Stated there had been a big chart giving directions on how to do cleaning, but it had crumbled and was thrown away. No copy was made before discarding it.</p> <p>*Stated they cleaned both of the whirlpool tubs (one on Happy Trails wing and one on Rising Sun wing) the same way.</p> <p>Review of manufacturer's 2010 instructions for the use of Virex II 256 revealed: *Its use to clean whirlpool tubs was not listed on the information label. *It should have been mixed in a 1 to 256 dilution or one-half ounce per gallon of water.</p> <p>Review of the provider's undated Cleaning Policy for Bath Tubs and Showers revealed: *Rubber gloves should have been worn when cleaning the tub or shower. *The tub, chair, and belt should have been scrubbed with a brush. *They were to follow the manufacturer's guidelines using the recommended solutions.</p> <p>Interview on 7/9/15 at 9:05 a.m. with the director of maintenance revealed: *The distributor told him it was okay to use the Virex in whirlpool tub systems. He stated there had been an e-mail sent to support the use of Virex to clean whirlpool tub systems. but he had not located it. He stated it was the same chemicals as used in other cleaners specifically for whirlpool tubs. He stated he would provide the Virex distributor's contact information and the whirlpool parts supplier's contact information. -There was no documentation of that information. *There were no specific instructions on using Virex in whirlpool tub systems, or information if it should be rinsed out of the system at the end of</p> | F 441 | | |

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| F 441 | <p>Continued From page 118 the cleaning. *There were no instruction manuals for the two whirlpool tubs.</p> <p>Interview on 7/9/15 at 10:05 a.m. per telephone revealed: *He believed there was an e-mail but he was traveling at the time and would call again.</p> <p>Attempted contact by e-mail with the distributor on 7/13/15 at 8:25 a.m. got a later e-mail response at 4:31 p.m. which revealed he was unable to locate the e-mail regarding Virex.</p> <p>4. Observation on 7/13/15 at 2:09 p.m. of resident 1's dressing change by registered nurse (RN) A with assistance of CNA G revealed: *CNA G was in resident 1's room with the resident in the bathroom. *RN A walked in with supplies (glove, dressing, and scissors) and laid them on the bedside stand without making a clean surface on which to place the clean supplies. *RN A opened the dressing packaging and then put on gloves. *CNA G positioned the resident for the dressing change. He was standing with assistance of CNA G at the bathroom doorway. *The gait belt had been placed around the resident's waist with the tail end of the gait belt hanging down in the middle of his buttocks. *He then pulled the tail end of gait belt out of the way of his vision with his right hand, so that the gait belt was against the resident's skin and dressing. He then pulled off the dressing over the wound on the left buttock revealing a jagged two inch long wound. *He then pulled the tail end of the gait belt to the left buttock and pulled off the dressing on the</p> | F 441 | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435129 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/14/2015 |
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| NAME OF PROVIDER OR SUPPLIER DELLS NURSING AND REHAB CENTER INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 THRESHER DR DELL RAPIDS, SD 57022 | |
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| F 441 | <p>Continued From page 119</p> <p>right buttock revealing a small open wound at the very bottom center area of the buttock</p> <p>*He discarded the used dressings, then picked up the scissors and dressing placing his thumb directly over the area on the dressing that would cover the wound. He cut the dressing to cover the area of the wound, placed the back of the dressing on the clear adhesive, and then placed the dressing over the wound on the lower right buttock and secured it in placed.</p> <p>*He repeated the same process again placing his thumb directly over the dressing material that would cover the wound, and placed the dressing and adhesive over the wound on the left buttock.</p> <p>*He did not clean either wound before applying the new dressing.</p> <p>*He took his gloves off, gathered the empty bandage wrapper and scissors, and left the room without washing his hands.</p> <p>*He went to the medication room where the gloves and dressing packaging were discarded, and then washed his hands.</p> <p>*CNA G left resident 1's room wearing the gait belt around her waist that had touched the wounds and skin on resident 1's buttocks.</p> <p>Review of the provider's 6/3/15 Clean Dressing Change procedure revealed:</p> <p>*A clean field should have been made to put the clean supplies on.</p> <p>*Soiled dressings should have been placed in a plastic bag.</p> <p>*Soiled gloves should have been removed after the soiled dressings had been removed and discarded.</p> <p>*Wounds should have been cleaned.</p> <p>*Used gloves and disposable supplies should have been placed in a plastic bag when removed from the room.</p> | F 441 | | |

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| F 441 | Continued From page 120 5. Interview on 7/14/15 at 10:20 a.m. with the director of nursing concerning shower and tub cleaning and resident's dressing changes revealed: *She agreed the manufacturer's instructions and the provider's policies should have been followed in the cleaning of the shower area and whirlpool tubs. *She agreed the observed dressing change observed had not followed the provider's procedure. Surveyor: 22452 6. Observation on 7/8/15 at 12:00 noon of certified nursing assistant J revealed she: *Performed Foley catheter (tube inserted into the bladder to drain urine) care on resident 9. *Washed her hands after the care with her gloves on. *Did not remove her gloves or wash her hands until after she had emptied the Foley catheter urinary drainage bag. *Touched the resident's bed remote control and call light with her soiled gloves. Refer to F315, finding 1. Surveyor 33265 Review of provider's undated Gloves procedure revealed gloves: *Were used to protect both healthcare worker and resident from infections. *Need to be changed after contact with soiled materials. *Were not to be washed for reuse. | F 441 | | |
| F 456 SS=E | 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential | F 456 | F456 Parts have been ordered and will be installed upon arrival. Spare parts also ordered to have on hand for future need. | 8/12/2015 |

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| F 456 | <p>Continued From page 121 mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, record review, and manufacturers' instructions, the provider failed to maintain: *Safety clips on three of three Volaro lifts (equipment used to move a resident from one place to another place) that were currently being used for residents. *Retainer springs on two of two Volaro Stands (machines used as an aid to stand residents up). *One of two washing machines in the laundry room from leaking. Findings include:</p> <p>1. Observation on 7/7/15 from 8:00 a.m. to 9:00 a.m. throughout the building revealed: *Multiple lifts to move residents from one place to another place and machines used to aid in standing. *Five were from one manufacturer Volaro. -Three were mechanical lifts -Two Volaro Stands were used to aid in standing and moving residents. *There was no identification on those Volaro lifts and Volaro Stands identifying one from the other for tracking purposes. *Safety clips or strap retainer springs were missing from all of the five machines.</p> <p>Review of the preventative maintenance logs revealed: *All lifts were to be checked for proper functioning semi-annually.</p> | F 456 | <p>Each lift will be numbered and staff will be educated on inspection of the safety devices. Staff will be educated to complete a work order request for any issues that are discovered. The Lifts will continue to be inspected by maintenance according to the monthly P.M. manual.</p> <p>The washing machine leak will be repaired. Staff will be educated to fill out work order request form if leaks or other issues arise.</p> <p>Preventative Maintenance logs were reviewed to ensure they were complete and accurate.</p> <p>Environmental Services Director or designee will perform audits to ensure lifts and washing machines are in good condition and preventative maintenance logs are complete and accurate, for four weeks and monthly for two more months, then until directed otherwise by the QAPI Committee. <i>DW/SOAH/JT</i></p> <p>Environmental Services Director or designee will present findings at the monthly QAPI meetings for review.</p> | | |

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| F 456 | <p>Continued From page 122</p> <p>*The lifts were documented as checked on 12/24/15 which was a date in the future and July 2014.</p> <p>Interview on 7/8/15 at 8:50 a.m. with the maintenance director revealed he did not know the number of lifts and equipment used to aid in standing that were in the building.</p> <p>2. Observation and interview on 7/8/15 at 8:55 a.m. with laundry aides E and F of the laundry area revealed: *One of the two washing machines was leaking. Moisture and rust buildup was surrounding the bottom of the machine. *The laundry aides stated it had been "leaking awhile."</p> <p>Interview on 7/8/15 at 4:17 p.m. with the maintenance director revealed he had not been told the washing machine was leaking.</p> <p>3. Review of the preventative maintenance logs revealed: *The log sheets for 2014 dally, weekly, and monthly preventative measures were filled in. *None of the log sheets for 2015 were filled in. *The monthly log worksheet listed inspecting plumbing for leaks.</p> <p>Policies on maintenance of equipment were requested, however none were received before the end of the survey.</p> <p>Review of manufacturer's 8/27/09 User Manual for the Volaro lift revealed: *Safety retention clips were to provide extra safety even if slack in the sling occurred. *Suggested visual check of all external hardware</p> | F 456 | | | |

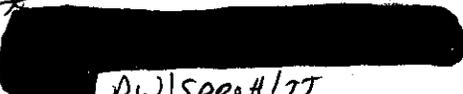
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| F 456 | Continued From page 123 every three months. Review of the manufacturer's 7/23/10 Operator Manual for the Volaro Stand revealed: *Operators were to make sure the loops from the sling were properly nested in the bottom of the hooks before lifting or transferring a resident, and that both retainer springs were functioning. *A general visual inspection of the external parts and all functions could be done at any time to ensure no damage had occurred to those parts. *Strap retainer springs were listed as lift items to inspect. Interview on 7/14/15 at 8:40 a.m. with the administrator revealed he agreed the: *Preventative maintenance logs needed to be completed and kept at facility. *Washing machine leak should have been reported and the leak repaired. *The Volaro lifts and Volaro Stands need to be inspected routinely to ensure safety clips and retainer springs are in place and functioning. Interview on 7/14/15 at 10:20 a.m. with the director of nursing revealed she agreed the Volaro lifts and Volaro Stands need to be inspected routinely to ensure safety clips and retainer springs are in place and functioning. | F 456 | | | |
| F 493 SS=H | 483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is | F 493 | F493 Facility has full time employed Administrator who is licensed by the State and responsible for the management of the facility. <i>*Governing body president visits the facility at a minimum of twice monthly and is available to the administrator for consultation in between visits. owl s2004/1/15</i> | 8/12/2015 | |

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| F 493 | Continued From page 124 licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, job description review, and policy review, the governing body failed to ensure the facility was managed in a manner that: *A change in condition for 1 of 1 sampled resident (14) was appropriately assessed, treated, and documented. *Pain was addressed and managed for 1 of 1 sampled resident (7). *Interventions were followed to prevent recurrent urinary tract infections for 1 of 2 sampled residents (9) who had an indwelling Foley catheter (tube inserted into the bladder to drain urine). *There was a medical diagnosis to warrant the use of an indwelling Foley catheter for 1 of 2 sampled residents (6). *Behavioral disturbances were identified and treated for 1 of 15 sampled residents (2) who displayed increased agitation. *Ensured neglect had not occurred for 1 of 1 sampled resident (13) who needed assistance with transferring from one place to another resulting in a major injury. *Ensured neglect had not occurred for 1 of 4 sampled residents (6) who used a Hoyer lift (equipment used to transfer a resident from one place to another place) for transfers resulting in her falling out of the sling. *Ensured neglect had not occurred for 1 of 1 sampled resident (14) who used her call light to | F 493 | Administrator will ensure resident change in conditions is appropriately assessed, treated, and documented; pain is addressed and managed; interventions are followed to prevent recurrent UTI's for residents with indwelling Foley catheter; medical diagnoses are obtained to warrant the use of an indwelling Foley catheter; behavioral disturbances are identified and treated for residents who display increased agitation; ensure neglect does not occur for residents who need assistance with transferring from one place to another resulting in a major injury; ensure neglect does not occur for residents who use a Hoyer lift for transfers resulting in injury; ensure neglect does not occur for residents who use call light to request staff assistance resulting in mental anguish; pressure ulcers are assessed and treated; falls with injuries are assessed, investigated, and interventions followed; antipsychotic medication is not used for staff convenience of agitation and anxiety; appropriate diagnosis and non-pharmacological interventions are not used for an as needed medication. *  DWLS200H/JJ *  DWLS200H/JJ | | |

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| F 493 | <p>Continued From page 125</p> <p>request staff assistance resulting in mental anguish when they refused to get her out of bed.</p> <p>*Pressure ulcers for 3 of 3 sampled residents (1, 6, and 7) were assessed and treated.</p> <p>*Falls with injuries for 6 of 6 sampled residents (1, 2, 5, 6, 9, and 13) were assessed, investigated, and interventions followed.</p> <p>*An antipsychotic medication (alters mood and behavior) for staff convenience of agitation and anxiety had not been used for 1 of 1 sampled resident (2).</p> <p>*An appropriate diagnosis and non-pharmacological interventions had been used for an as needed (PRN) medication Haldol (a mood and behavior altering medication for 1 of 1 sampled resident (2).</p> <p>Findings include:</p> <p>1. Interview on 7/14/15 at 2:00 p.m. with the governing body (consisted of one person) regarding the above issues revealed:</p> <p>*He felt the administration had kept him informed of any concerns with the residents.</p> <p>*The administrator had communicated to him verbally, and he had not documented anything down.</p> <p>*The administrator and the director of nursing (DON) had talked about the multiple falls they had in the facility. He had not given them any specific instructions on the falls, as they were very resident specific.</p> <p>*He knew they had removed all the TABs (alarm attached to the resident that would sound when the resident tried to self-transfer). He was not aware the facility had not put any interventions in place for each specific resident when they had removed the TAB alarm.</p> <p>*He would try and come to their quarterly Quality Assurance Performance Improvement (QAPI)</p> | F 493 | <p><i>* Administrator or designee will monitor the above indicated measures and ensure findings are addressed through the auditing process weekly for four weeks, then monthly for eleven months. The administrator will share and discuss findings with the governing body president during facility visits and/or as necessary per phone or email.</i></p> <p><i>the administrator or designee will present findings monthly at QAPI meeting. Findings will be presented and reviewed until the committee directs otherwise. owl5000H/JT</i></p> | | |

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| F 493 | Continued From page 126 meeting. He had last attended on March 18, 2015. *The administrator would usually inform him of the monthly QAPI meetings, but he did not document any of the meetings. *He usually would come to the facility more frequently whenever he had a change in administration, then would "wean himself away." *He confirmed the present administrator had been at the facility for two months, and the director of nursing (DON) had been in her position since November 2014. *He had not been at the facility since the March 2015 QAPI meeting. | F 493 | | |
| F 501 SS=E | Refer to F156, F157, F159, F166, F222, F224, F226, F241, F248, F250, F253, F280, F281, F283, F309, F311, F314, F315, F323, F329, F371, F425, F441, F456, F501, and F520. 483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on interview, and job description, the medical director failed to: *Implement and evaluate resident care policies and procedures that reflect current standards of practice for the assessment and investigation of | F 501 | F501 Responsibilities of Medical Director were reviewed to ensure implementation of resident care policies and coordination of medical care was appropriate. Normal Medical Director processes will be continued, with further emphasis on involvement in the implementation and evaluation of resident care policies and procedures for the assessment and investigation of falls with injuries and proper intervention follow through. <i>* Medical Director QAPI attendance will be monitored to ensure at least quarterly attendance. owls000H/OT</i> | 8/12/2015 |

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| F 501 | <p>Continued From page 127</p> <p>falls with injuries for six of six sampled residents (1, 2, 5, 6, 9, and 13).</p> <p>*Ensure interventions were followed to prevent recurrent urinary tract infections for one of two sampled residents (9) who had an indwelling Foley catheter (tube inserted into the bladder to drain urine). Findings include:</p> <p>1. Phone interview on 7/9/15 at 11:35 a.m. with the medical director regarding the above residents' falls and urinary tract infections revealed:</p> <p>*He got a faxed report from the facility every month regarding their monthly Quality Assurance Performance Improvement (QAPI) meetings. *He attended their quarterly QAPI meetings. *He made rounds every month to the facility to see his residents. *The facility kept him informed of fall issues for specific residents. *He usually would give input for residents who were his patients, but referred the staff to consult the other residents' primary physicians. *He did not recall the facility had ever requested his input regarding falls. *The facility used to bring the tracking and trending of urinary tract infections to QAPI, but they had not done that for awhile. He had not asked them why they had not. *He was not sure why residents with Foley catheters were being put on antibiotics unless they were showing symptoms of a urinary infection.</p> <p>Review of the 12/10/05 Medical Director job description revealed: *"The medical director helps the facility identify, evaluate, and address/resolve medical and</p> | F 501 | <p>Administrator or designee will perform audits to ensure Medical Director responsibilities and involvements are completed and appropriate for four weeks and monthly for two more months.</p> <p>Administrator or designee will present findings at the monthly QAPI meetings for review.</p> | | |

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| F 501 | Continued From page 128 clinical concerns and issues that affect resident care, medical care or quality of life." *"The medical director helps ensure that appropriate systems exist to facilitate good medical care, establish and apply good monitoring systems and effective documentation and follow-up of findings." *"The medical director helps the facility to incorporate current standards of practice into residents' care policies and procedure/guidelines to help assure that they address the needs of the resident." *"In addition, other areas for medical director input to the facility may include: -Reviewing individual resident cases as requested or as indicated. -Discussing and intervening [as appropriate] with a health care practitioner about medical care that is inconsistent with applicable standards of practice. -Assuring that a system exists to monitor the performance. -Identifying facility or practitioner education and informational needs. -Helping educate and provide information to staff, practitioners, residents, families, and others." | F 501 | | |
| F 520 SS=F | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance | F 520 | F520 Quality Assurance (QA) program was reviewed to ensure it maintained to identify concerns and to develop and implement corrective action. Appropriate discussion and changes will be made after following the steps identified in the facility policy. | 8/12/2015 |

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| F 520 | <p>Continued From page 129</p> <p>committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review and interview, the provider failed to ensure an effective quality assurance (QA) program had been maintained to identify concerns and to develop and implement corrective action. Findings include:</p> <p>1. Interview on 7/13/15 at 3:00 p.m. with the social worker (SW) regarding QA revealed she: *Attended the monthly and quarterly meetings. *Had been doing audits since August 2014 regarding residents' call lights. *Stated they randomly had complaints from residents on how long their call lights were on, but no residents had talked to her for quite sometime about them. *Primarily did random audits on how long call lights were on during the day shift and occasionally on weekends when she was there. *Had not done any audits on call lights on the</p> | F 520 | <p>* [REDACTED] DW/SOD/H/JT</p> <p>* [REDACTED] DW/SOD/H/JT</p> <p>* Administrator or designee will audit to:</p> <ul style="list-style-type: none"> • ensure necessary staff is present and included in QAPI, • ensure auditing and monitoring processes are timely and identified issues are addressed or additional solutions explored, • ensure all facility staff and residents and families are made aware of processes as they change, improve, and come to resolution. <p>Administrator or designee will present findings monthly at the QAPI meeting until directed otherwise by the Committee. DW/SOD/H/JT</p> | |

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

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OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435129 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 07/14/2015 |
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| NAME OF PROVIDER OR SUPPLIER DELLS NURSING AND REHAB CENTER INC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 THRESHER DR DELL RAPIDS, SD 57022 | | |
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| F 520 | <p>Continued From page 130 evening or night shift.</p> <p>*Was not aware of random residents' complaints from the resident council that call lights were on sometimes greater than two to three hours.</p> <p>*Had identified call lights being on for a long time at meals was a concern.</p> <p>*Had informed the director of nursing (DON) about call lights at meals. They had discussed changing the staffing during those times, but they had made no changes since she had started her audits in August 2014.</p> <p>*Did not visit with residents or staff at the times she was timing how long a call light was on.</p> <p>*Was only documenting on her audits how long random room call lights were on and documented that.</p> <p>*Thought an acceptable time frame set by the facility for answering a resident's call light was five minutes or less.</p> <p>*Had found during her audits for January 2015 through May 2015:</p> <ul style="list-style-type: none"> -Nine residents' call lights were answered in three minutes or less. -Twelve residents' call lights were answered in four to nine minutes. -Three residents' call lights were answered in ten minutes or more. <p>*Had done nothing with the above call light times other than report them at QA.</p> <p>*Felt they had discussed call lights, but no one had made a decision to make any staff changes to get them answered in a more timely manner especially at mealtime.</p> <p>Interview on 7/13/15 at 4:00 p.m. with the environmental director regarding QA revealed he:</p> <ul style="list-style-type: none"> *Attended the monthly and quarterly meetings. *Was not aware of the random residents complaints from resident council about their | F 520 | | |

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| F 520 | <p>Continued From page 131</p> <p>concern with missing laundry items, especially their Ted hose (support stockings). *Had done an audit from January 2015 through May 2015 regarding missing residents' clothes. *Had determined no changes needed to be made in how residents' clothing was handled. *Stated most items of clothing either the resident had misplaced, or the clothing had accidentally been placed in another resident's closet and had been returned to the original owner. *Stated regarding missing Ted hose it was primarily a nursing issue. He was not aware how many pair of Ted hose the resident actually had to begin with. *Was unsure who kept track of ordering Ted hose for the residents to determine how many pair they actually had. *Stated there had been no other concerns brought to his attention from housekeeping, laundry, or environmental services that he needed to audit.</p> <p>Interview on 7/13/15 at 4:30 p.m. with the registered nurse Minimum Data Set assessment coordinator regarding QA revealed she: *Did not attend the monthly or quarterly meetings. *Would give any concerns she had with residents to the director of nursing (DON). *Stated a fall committee had been started the past year that she thought was as an extension of QA. The committee had met weekly initially but had recently been decreased to every two weeks. *Was on that committee in addition to the DON, a certified nursing assistant, and a restorative aide. *Stated they had discontinued all residents TABs (alarm that attaches to the resident and sounds when the resident attempts to self-transfer) during June 2015 after they had gone to a healthcare convention.</p> | F 520 | | |

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| F 520 | <p>Continued From page 132</p> <p>*Stated they had not put any other interventions for fall prevention in place for each resident as they removed their TABs alarms.</p> <p>*Was not sure if the residents who used the TABs alarms had an increase in falls since the monitors had been removed.</p> <p>*Stated no real increase in falls, but a couple that had fallen had more severe injuries.</p> <p>*Stated resident 5 was hard to evaluate whether he fell to the floor or just laid himself on the floor.</p> <p>*Stated resident 5 would lay himself on the floor, because he had told them it was cooler on the floor.</p> <p>*Was unsure when asked if staff had looked into the temperature of his room to see if it was cooler on the floor.</p> <p>*Stated they looked at specific resident falls during the fall committee meetings, but had made no significant changes in their overall fall prevention program.</p> <p>Review of the 5/14/15 through 6/18/15 Falls Committee Minutes revealed:</p> <p>*5/14/15: Resident 5 had a fall on 4/16/15, 4/22/15, and 5/1/15.</p> <p>*5/21/15: Resident 5 had a fall on 5/4/15.</p> <p>*5/28/15: New fall investigation sheets to start 6/1/15. (Sheets provide more information for investigation purposes.)</p> <p>*6/4/15: Resident 5's TABs alarm discontinued on 5/26/15. He sustained a fall on 6/1/15.</p> <p>*6/18/15: Resident 2's TABs alarm discontinued on 5/26/15. He sustained a fall on 6/9/15 with lacerations (cuts) and bruises to the face and eyes.</p> <p>*6/24/15: Resident 5 had a fall on 6/23/15 with lacerations to the face.</p> <p>Interview on 7/13/15 at 5:00 p.m. with the</p> | F 520 | | | |

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| F 520 | <p>Continued From page 133</p> <p>administrator and the DON regarding QA revealed:</p> <ul style="list-style-type: none"> *Evaluating falls was an ongoing process. *A fall prevention program was started in April 2015. They had started to look at the use of high/low beds and getting therapy involved. *They really had not talked about urinary tract infections since the DON had started her role in November 2014. *The medical director attended their quarterly meetings, and they sent him copies of their monthly meeting reports. *The medical director was good with giving ideas for his patients (residents), but was not real forthcoming with ideas for other physicians' patients (residents). *They stated they were aware answering residents' call lights had been a problem especially at mealtime. *They had talked about staff changes to cover the nursing wings during resident meals, but so far had made no changes. *The DON stated she had never heard resident 5 was laying on the floor as it was cooler. It had never been brought up when they had discussed any of his falls. *They agreed they talked a lot about things in QA but rarely made any changes. | F 520 | | |

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| NAME OF PROVIDER OR SUPPLIER DELLS NURSING AND REHAB CENTER INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 THRESHER DR DELL RAPIDS, SD 57022 | |
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| K 000 | INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/7/15. Dells Nursing and Rehab Inc. was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 7/7/15 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards. | K 000 | K000 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 and federal law. Without waiving the foregoing statement, the facility states that with respect to: | |
| K 032 SS=C | NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and document review, the provider failed to maintain at least two conforming exits from each floor level of the building. The basement had only one conforming exit. Findings include: | K 032 | K032 | F |

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

TITLE

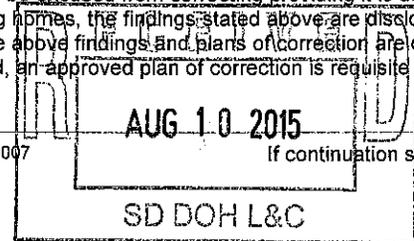
(X6) DATE

[Signature]

ADMINISTRATOR

8/7/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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| K 032 | <p>Continued From page 1</p> <p>1. Observation at 11:00 a.m. on 7/7/15 revealed the basement had only one conforming exit directly to the exterior of the building. The second egress routes were through hazardous areas (the boiler and laundry rooms) to an area well equipped with a fixed ladder. Review of previous survey data confirmed that condition had existed since the original construction.</p> <p>The building meets the FSES. Please mark and "F" in the completion date column to indicate correction of the deficiencies identified in K000.</p> <p>This deficiency would not affect any of the resident that reside in the facility.</p> | K 032 | | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10613 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 07/14/2015 |
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NAME OF PROVIDER OR SUPPLIER
DELLS NURSING AND REHAB CENTER INC

STREET ADDRESS, CITY, STATE, ZIP CODE
**1400 THRESHER DR
DELL RAPIDS, SD 57022**

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| S 000 | Initial Comments Addendums noted with an asterisk per 8/12/15 telephone to facility administrator and DON. DW/SCDH/JJ | S 000 | S000 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 and federal law. Without waiving the foregoing statement, the facility states that with respect to: | |
| S 475 | 44:04:18:13 Supervision of Students Students in a nurse aide training program may not perform any services unless they have been trained and found to be proficient by the instructor. Students in a training program may perform services only under the supervision of a licensed nurse. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32335 Based on record review and interview, the provider failed to ensure: *Sixteen hours of skills training had been completed prior to nurse aide students having direct contact with the residents. *The sixteen hours of supervised practical training had been done by a licensed nurse. Findings include: 1. Record review and interview on 7/8/15 at 3:00 p.m. with the director of nursing (DON) and the nurse aide training program (NATP) instructor revealed: *They used the We Care Online curriculum for the classroom training. *Students completed that training on their own. | S 475 | S475 CNA students will complete 16 hours orientation with NATP instructor prior to interaction with resident's under CAN instruction DON or designee will perform audits on CNA training program to ensure appropriate time specifications are followed with NATP instructor prior to interaction with residents under CNA instruction for four weeks and monthly for two more months. DON or designee will present findings at the monthly QAPI meetings for review. all participants in DW/SCDH/JJ | 8/12/2015 |

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

TITLE

(X6) DATE

STATE FORM

6899

MI5H11

ADMINISTRATOR
RECEIVED 8/12/2015

If continuation sheet 1 of 2

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| S 475 | <p>Continued From page 1</p> <p>*After the student completed the online portion of the training they would meet with the NATP instructor.</p> <p>*The instructor completed sixteen hours of skills training with the students.</p> <p>*The first eight hours were completed in a vacant resident room, if available, where they worked on skills.</p> <p>*The next eight hours she had them working with residents.</p> <p>*The rest of the students' hours were completed with certified nursing assistants (CNA).</p> <p>Interview on 7/14/15 at 8:40 a.m. with the DON revealed she thought the sixteen hours of supervision could be monitored by the CNAs and that it did not have to be a licensed nurse. Review of the regulation revealed it was to be a licensed nurse.</p> <p>Review of the We Care Online syllabus revealed it had not addressed the required hours for the skills training.</p> | S 475 | | |