

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/26/2015
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
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F 000	INITIAL COMMENTS Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/24/15 through 2/26/15. Palisade Healthcare Community was found not in compliance with the following requirements: F242, F246, F250, F279, F280, F281, F323, F332, F364, F371, F431, F441, F467, and F514.	F 000			
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review and interview, the provider failed to implement bath schedule preferences for two of six unidentified residents. Findings include: 1. Confidential interview on 2/24/15 at 3:45 p.m. with a group of residents revealed two residents were not receiving their bath when they wanted them. Both unidentified residents were alert and oriented to person, place, situation, and time. Upon admission they had been told they could have a bath during the day or at night. One unidentified resident was scheduled to receive a	F 242	F242 Right to Make Choices 1.No specific residents were cited in the 2567. 2.All residents are potentially at risk. 3.Residents are allowed choices in their bathing schedules, including type, frequency and timing of their baths. All staff will be educated by the DON or designee on or before April 17 th , 2015 on resident bathing choices. Resident choices are obtained on admit and quarterly with their intake assessments by Social Services and Activities and then quarterly with each MDS assessment. All cognitively intact residents were interviewed 1:1 on March 10 th , 2015 by the DON and Nurse Manager for bathing preferences.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul Wells TITLE: Adm. (X6) DATE: 3-17-15

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.

MAR 20 2015
SD DOH L&C

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

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F 242	Continued From page 1 bath on Wednesday and Saturday, but she was not getting it every Saturday. The second resident wanted to have her bath at night and was told they stopped giving baths at 4:30 p.m. She was not getting baths at night as preferred. Interview on 2/26/15 at 1:20 p.m. with the director of nursing and certified nursing assistant (CNA) E revealed: *Residents could have a bath Monday through Saturday in the morning, afternoon, or evening. *They asked residents upon admission into the facility what time of day they wanted their bath. -That information had not been documented. *The current bath schedule had not identified the residents' preferred bath times. *Baths were being stopped at 4:30 p.m., and the evening bath aid was helping put residents to bed instead of giving baths.	F 242	Social Services (SS) or designee will complete written audits weekly x 4, then monthly x 3 on resident bathing choices. A minimum of 3 residents will be reviewed with each audit 4. SS or designee will report the results of the written audits to the facility QAPI committee monthly for review and recommendations.		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, and interview, the provider failed to assess wheelchair positioning and the need for a physical devices for 1 of 11 sampled residents (8). Findings	F 246	F246 Accommodation of Needs 1. Resident #8 will be reassessed for positioning needs at the dining room table on or before April 17 th , 2015. 2. All residents are potentially at risk. 3. All staff will be educated by the DON or designee on or before April 17 th , 2015 on positioning of residents in the dining area and accommodation of needs.	4-17-15	

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F 246	<p>Continued From page 2 include:</p> <p>1. Observation on 2/24/15 from 12:10 p.m. through 12:55 p.m. of resident 8 revealed he had been brought to the dining room table and positioned sideways to the table. His knees were not at a 90 degree angle and would not fit under the table. His knees were raised due to a rectangular cushion (foot plate) placed on the foot pedals. The back of the cushion was supposed to be behind his legs but was bent. He had on insulated protective boots that raised his feet off the cushion. He had attempted to adjust himself in the chair but was unsuccessful. He had been served pizza at 12:20 p.m. Staff sat down with him at 12:30 p.m. to assist him with his meal. He had a difficult time reaching for his drinking glasses due to his position at the table.</p> <p>Observation on 2/24/15 at 5:20 p.m. of resident 8 revealed he had been sitting sideways at the dining room table. His knees were raised and would not fit under the table. The foot plate was still present. He had difficulty eating due to his positioning.</p> <p>Review of resident 8's 12/22/14 Minimum Data Set (MDS) assessment revealed he needed extensive assistance from two staff members for transferring, ambulating, and dressing. He needed supervision of one staff member for eating.</p> <p>Interview on 2/26/15 at 2:35 p.m. with physical therapist I and occupational therapist J regarding resident 8 revealed physical therapy had ended on 2/9/15 due to lack of motivation. He had started occupational therapy on 2/21/15. Neither department had ordered the foot plate to be used</p>	F 246	<p>The DON or designee will complete written audits weekly x 4, then monthly x 3 on positioning in the dining area. A minimum of 3 residents will be included in each audit.</p> <p>4. Results of the written audits will be reported to the facility QAPI committee monthly by the DON for review and recommendations.</p>	4.17.15	

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F 246	Continued From page 3 in his wheelchair. He should have been pushed up to the table and not sitting sideways for meals. Interview on 2/26/15 at 2:50 p.m. with the director of nursing revealed she had referred resident 8 to occupational therapy to help him with eating. Interview at the same time with the MDS coordinator regarding resident 8 revealed she had not completed a physical device assessment for the foot plate. She was unaware he had the foot plate on his wheelchair. She did not know where it had come from. She removed the foot plate and adjusted his foot pedals to be at a 90 degree angle for when he was in the chair. An assessment should have been completed before adding anything to his wheelchair. He also should have been pushed up to the table so his knees would have been under the table.	F 246		
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: 33488 Based on observation, interview, record review, job description review, and policy review, the provider failed to ensure medically related social services were carried out for two of eleven sampled residents (1 and 11). Findings include:	F 250	F250 1.Residents 1 & 11 are unable to be corrected for past non-compliance. 2. All residents are potentially at risk. 3. The LSW noted in the 2567 has resigned the position at this facility and is no longer employed. A new Social Worker has been hired and started in the role. The Administrator will review the finding of this deficiency with the new associate on or before April 17 th , 2015 and orientation to the position will include the role of SW in relation to F250. Residents #1 & #11 will be re-assessed by the SW on or before April 17 th , 2015 to include psychosocial well-being.	

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F 250	<p>Continued From page 4</p> <p>1. Observation and interview on 2/24/15 at 9:00 a.m. during initial tour with resident 11 revealed:</p> <ul style="list-style-type: none"> *She was wheeling herself in her wheelchair down the 100 wing. *She was wearing a hospital style red "ALLERGY" band on her right wrist and had a cotton ball covered in paper tape on her right inner forearm by her elbow. *When asked if she had been in the hospital recently she said she had just returned early that morning. *She stated she had done "a bad thing." *Further questioning revealed she had stolen from another resident, and as a result she had "tried to kill herself." *Nursing staff sent her to the hospital for a psychological evaluation. She returned a "couple of hours later." *The reason she wanted to harm herself had been she was upset because the provider told her she had thirty day's to find a place to live, and she had no where to go. <p>Review of resident 11's interdisciplinary progress notes in the medical record revealed:</p> <ul style="list-style-type: none"> *At 6:17 p.m. on 2/23/15: <ul style="list-style-type: none"> -The resident had reported making comments about hurting herself to the certified nursing assistants (CNA) and the nurse. -She reported she had done "something bad. I need help." -She was sent to the hospital emergency room for evaluation. -The primary physician was notified of the transfer at that time. *At 11:30 p.m. that same day: <ul style="list-style-type: none"> -She returned from the hospital. -Nursing staff asked the resident what the doctor said to her. 	F 250	<p>The Administrator or designee will complete written audits weekly x 4, then monthly x 3 on resident psychosocial well-being. A minimum of 3 residents will be included in each audit.</p> <p>4. The administrator or designee will report the results of the written audits to the facility QAPI committee monthly for review and recommendations.</p>	4-17-15	

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F 250	<p>Continued From page 5</p> <p>-She replied to the nurse "They told me I am not crazy, and that I have deep-rooted emotions."</p> <p>*The nursing progress notes made no mention of her hospital discharge instructions or interventions that would have been needed to be implemented for her safety.</p> <p>*From the time of her return from the hospital there had been no documentation by nursing staff of the resident's mental status nor any interventions that were put in place for her safety.</p> <p>*The following day on 2/24/15 at 4:48 p.m. was the first note documented by social services. The note revealed the licensed social worker (LSW) was notified by the consulting mental health provider that:</p> <p>-The resident had indicated she "was having thoughts of harming herself."</p> <p>-They (consulting mental health provider) felt she would not act on it.</p> <p>*From the time the resident had returned from the hospital after her initial evaluation to the time social services had documented any interaction with the resident was over sixteen hours.</p> <p>Interview on 2/26/15 at 2:30 p.m. with the LSW regarding resident 11 revealed:</p> <p>*She was not directly notified the morning of 2/24/15 by nursing staff of the resident's suicidal thoughts and risk of self-harm.</p> <p>*Her routine was to have checked the "dashboard" (area in the electronic medical record that lists updates on resident's conditions) each morning for any changes that her department (social services) would need to address for residents.</p> <p>*She stated she had not assessed the resident at any time prior to her progress note she had documented on 2/24/15 at 4:48 p.m.</p> <p>*She stated she had waited for the consulting</p>	F 250		
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F 250	<p>Continued From page 6</p> <p>mental health provider to see the resident first. *She had not placed any interventions on the care plan until 2/25/15 the following day sometime after 5:00 p.m. *She had not notified other departments (specifically nursing) of those new interventions. *She agreed unless nursing happened to look at the resident's care plan at the end of that day they would not have known about the interventions. *She agreed she should have advised the nurse on duty there, so the interventions could have been passed on in report and immediately implemented. *She agreed there needed to be better communication between departments regarding resident changes. *She agreed she had not assessed the resident in a timely manner after arriving for work that morning. *When asked how she advocated on behalf of the resident in a timely manner to ensure her safety she stated she had not.</p> <p>Interview and record review on 2/26/14 at 3:15 p.m. with the director of nursing (DON) and the director of clinical services consultant regarding resident 11 revealed they: *Agreed there were no interventions added to the care plan after she had returned from the hospital regarding her suicidal thoughts and risk for self-harm until after 5:00 p.m. on 2/25/15. *Agreed it was the expectation that nursing and or social services would place interventions upon return on behalf of any resident deemed at risk for self-harm or suicide. *Had not thought the resident was serious about her thoughts of self-harm. *Agreed there had been no documentation that anyone had checked on the resident or spoken</p>	F 250			

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F 250	<p>Continued From page 7</p> <p>with her documented in the progress notes to see if her mental status had changed in any way.</p> <p>*Had not put into place the interventions listed on the discharge instruction sheet received from the hospital. They had not considered it a signed order.</p> <p>*Were unaware nursing staff had documented they were aware of the instructions as they had written they had noted and timed them on 2/24/15 at 5:45 a.m.</p> <p>*Agreed they needed to have better communication between departments.</p> <p>*Agreed interventions should have been placed immediately following re-admission to the facility from the hospital for a resident at risk for self-harm.</p> <p>*Agreed they would have expected staff to consult the provider's policy regarding suicide for guidance.</p> <p>Review of the provider's 2010 Suicide Threats policy revealed staff "will monitor the resident's mood and behavior and update the care plan accordingly."</p> <p>Review of the provider's August 2013 Suicide Precautions policy revealed staff were to have:</p> <p>*Removed all equipment that could be used and/or cause harm.</p> <p>*Notified social services to inform him or her of the incident.</p> <p>*Documented events and updated the care plan.</p> <p>*"If there is no plan for suicide, the care plan needs to be updated to find out if the resident would comment about "wanting to die" and each time an assessment will be completed to assure there is no plan."</p> <p>Review of the provider's 2013 Suicide</p>	F 250			

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F 250	<p>Continued From page 8</p> <p>Precautions checklist revealed staff were to:</p> <ul style="list-style-type: none"> *Remove all potentially dangerous articles from the resident's room. *Frequency of checks were to be checkmarked at ten, fifteen or thirty minutes, an hour, every two hours, or every shift. *There was also a section for other interventions to be hand-written on in addition to those already mentioned and signatures of the interdisciplinary team. *A note at the bottom of the page required staff to start a separate flowsheet to document the resident's location and activity at the intervals listed above that the team determined would be needed. *That flowsheet was to be kept in the medication administration record (MAR) or in an area easily accessible to all staff assigned to monitor the resident. *The flow sheet was to be used until the team had determined the length of time for checks was no longer necessary. <p>Surveyor: 32335</p> <p>2. Interview on 2/25/15 at 8:30 a.m. with resident 1 revealed:</p> <ul style="list-style-type: none"> *She was under fifty-five years old. *She had gone into the hospital in December 2013. *She entered a different facility in January 2014. *She had been transferred from that facility on 4/30/14. *Her mother had passed away in December 2013 after she had gone into the hospital. *She suffered from depression and talked with a counselor from a contracted mental health provider. -She felt that helped. 	F 250		

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F 250	<p>Continued From page 9</p> <p>*December was a trigger for her depression due to her hospitalization and mother passing away. *She had not been able to have surgery for the cancer because of her size. *She received chemotherapy and radiation treatments. *She had been on a special diet due to her kidney disease, but they had recently changed it back to a regular diet. *She had pain in her back due to the nephrostomy tubes (a small rubber tube that is placed through a hole in the skin that extends into the kidney). *She also had cramping which caused her pain on a regular basis. *She was married but recently had discussed getting divorced. -She felt relieved when her husband stated that was what he wanted.</p> <p>Review of resident 1's medical record revealed she had the following medical issues: -Chronic kidney disease. -Cancer. -History of urinary tract infections. -Multiple sclerosis. -Diabetes. -Generalized pain.</p> <p>Review of resident 1's 1/26/15 Minimum Data Set (MDS) assessment revealed: *Her thinking ability was not impaired. *She needed extensive assistance from two staff members for moving in bed, transferring from place to place, dressing, using the bathroom, bathing, and personal hygiene. *She had been moderately depressed.</p> <p>Interview on 2/26/15 at 8:30 a.m. with the DON</p>	F 250		

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F 250	<p>Continued From page 10 and the nurse consultant regarding resident 1 revealed:</p> <ul style="list-style-type: none"> *The doctor had wanted to take the nephrostomy tubes out as they kept falling out. *She had refused to have them taken out. *She had stated to staff she had pain with the tubes in and with them out. *They had attempted to tape down the tubes, but she did not like the tape against her skin. *She had behaviors of acting out to get attention mainly from her husband. *Her husband used to visit frequently but had not been coming very often in the past few months. *Recently she had complained of pain so bad she had requested she be sent to the hospital. -Once the ambulance had been called she acted fine and had started playing games on her phone. -Her husband showed up at the hospital each time she went. -She would get lots of attention, as he would post information on social media about her being hospitalized. *The DON was unaware December had been a trigger for her depression. -She reviewed the mental health provider's notes, and it had not been addressed in their notes. <p>Review of resident 1's 12/17/14 psychological evaluation revealed:</p> <ul style="list-style-type: none"> *She had: <ul style="list-style-type: none"> -Significant limited coping skills. -No consistent approach when dealing with situations. -Struggled to maintain interpersonal relationships. -Self esteem difficulties. *The treatment plan recommendations were: <ul style="list-style-type: none"> -Therapy to focus on poor self esteem, poor interpersonal skills, coping strategies, relaxation strategies, stress management strategies, and 	F 250		
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F 250	<p>Continued From page 11</p> <p>sleep techniques.</p> <ul style="list-style-type: none"> -Present information verbally due to difficulty with visual memory. -Utilize notes and calendars. -Increase activity levels. -Continue with an exercise program. -Return to work or volunteer type activities. -Make a list of projects and develop time frames. <p>Review of resident 1's 1/26/15 care plan revealed:</p> <ul style="list-style-type: none"> *None of the above mentioned treatment recommendations had been included in it. *A goal for depression and anxiety had been initiated on 2/24/15. *There had been no goal to address her behaviors. *There had been no social service interventions listed. *There had been no identification of December being a trigger for her depression. *There had been no documentation of the potential divorce. *There had been no intervention to address the nephrostomy tubes coming out and what the future plan would be. <p>Review of resident 1's interdisciplinary notes from 11/13/14 through 2/19/15 revealed:</p> <ul style="list-style-type: none"> *There had been one social services note dated 11/21/14. -The LSW had attempted to get her admitted to an inpatient program due to her depression. -The inpatient program was supposed to have provided more information. -There was no follow-up documentation of that attempt at getting her admitted or other interventions to help with the depression. *There had been eight notes regarding crying 	F 250			

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F 250	Continued From page 12 episodes. *Four out of the eight notes stated medication had been given for the crying. -An antianxiety medication had been given three times and a pain medication one time. *Two out of the eight notes had no intervention listed. Interview on 2/26/15 at 11:00 a.m. with the LSW regarding resident 1 revealed she had: *Known her mother had passed away in December but had not thought of it as a trigger until this surveyor had mentioned it. *Known about the potential for the divorce but had not implemented any interventions. *Not care planned behavioral interventions or social service intervention. *Not documented interactions with her. Review of the LSW's 2/4/14 signed job description revealed she was to: *Ensure residents emotional and social needs were met or maintained. *Counsel residents to enhance coping with current illness and disabilities. *Assist residents to understand, accept, and follow medical recommendations. Review of the provider's July 2013 Documentation System policy revealed all observations and services performed should have been documented in the resident's medical record.	F 250			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279			

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F 279	<p>Continued From page 13 comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 16385 Based on record review, interview, and policy review, the provider failed to ensure one of one sampled resident (10) receiving peritoneal dialysis (removing waste products from the blood) and one of two sampled recent admission residents (8) receiving therapy services had a comprehensive care plan with individualized and measurable goals, approaches, and interventions. Findings include:</p> <p>1. Review of resident 10's medical record revealed: *The provider had not included interventions in her care plan to address peritoneal dialysis. *She was admitted on 1/26/15 with a diagnosis of end stage renal disease (chronic kidney disease).</p>	F 279	<p>F279 Develop Care Plans</p> <p>1. Residents #10 & #8 care plans will be updated on or before April 17th, 2015 to reflect this current status.</p> <p>2. All residents are potentially at risk</p> <p>3. The Interdisciplinary Team and nurses will be educated on or before April 17th, 2015 by the DON or designee on the care planning process.</p> <p>The DON or designee will complete written audits weekly x 4, then monthly x 3 on care planning of resident status. A minimum of 3 residents will be included in each audit.</p> <p>4. Results of the written audits will be taken to the facility QAPI committee monthly by the DON or designee for review and recommendations.</p>	4-17-15
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F 279	<p>Continued From page 14</p> <p>*Her February 2015 medication administration record revealed she was receiving peritoneal dialysis in the facility.</p> <p>*Review of her care plan revealed a dialysis focus initiated 2/20/15.</p> <p>-However no interventions had been included regarding receiving peritoneal dialysis in the facility.</p> <p>Surveyor: 33488 Interview and policy review on 2/26/15 at 3:15 p.m. with the Minimum Data Set (MDS) assessment coordinator, the director of nursing (DON), and the consulting director of clinical services regarding resident 10 revealed:</p> <p>*The DON was unaware the resident's peritoneal dialysis had not been specifically addressed on her care plan.</p> <p>*The MDS coordinator stated she had thought it was addressed in the provider's undated Emergency Care Measures for Dialysis Resident's policy.</p> <p>*After review of the resident's care plan the DON agreed it was not specific to the resident's needs of peritoneal and hemodialysis.</p> <p>*The DON was unaware that daily fistula (a surgical connection made between an artery and a vein used for hemodialysis) checks had not been added to her care plan.</p> <p>*The MDS coordinator stated it was addressed in the provider's undated Emergency Care Measures for Dialysis Resident's policy.</p> <p>*In review of that policy an absence of a bruit (sound) or thrill (pulsing sensation felt at the fistula) would result in immediate notification of the hospital dialysis department.</p> <p>*The DON agreed in order to assess if there were an absence of a bruit or thrill the fistula would</p>	F 279			

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F 279	<p>Continued From page 15 need to be checked. *She agreed it should have been care planned for nursing staff to do that daily.</p> <p>Surveyor: 32335 2. Review of resident 8's medical record revealed: *He had an admission date of 12/15/14. *He had been admitted due to acute kidney injury, dehydration, and right leg weakness. *He had started physical therapy (PT) on 12/16/15. *He had started occupational therapy (OT) on 2/21/15 to assist him with eating.</p> <p>Interview on 2/26/15 at 2:50 p.m. with the DON revealed she had referred resident 8 to occupational therapy to assist him with eating.</p> <p>Review of resident 8's 2/17/15 physician's order revealed: *The physician declined the order to discontinue PT. *The reason was because he was at "high risk to lose mobility on left side etc which will complicate future cares." *The physician ordered range of motion exercises to prevent worsening contractures through PT or nursing services.</p> <p>Review of resident 8's 12/17/14 care plan revealed: *He planned to return home in three months. *The only intervention for therapy was "encourage me to participate in therapy." *There was no documentation of when OT met with him or how often. *There was no documentation for the range of</p>	F 279		

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F 279	Continued From page 16 motion exercises he was to receive.	F 279		
F 280 SS=E	<p>3. Review of the provider's April 2013 Care Planning Process policy revealed: *Care plans should have included measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs. *The care plans should have included overall long term goals. *Goals helped to set parameters to determine if approaches or interventions were working or if the patient must be reassessed. *Individuals could have been admitted for rehabilitation in order to return to the community.</p> <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>	F 280	<p>F280 Revising Care Plan</p> <p>1. Residents 1, 2, 3, 10 & 11 will have their care plans revised on or before April 17th, 2015 to reflect their current status.</p> <p>2. All residents are potentially at risk.</p> <p>3. All staff will be educated on or before April 17th, 2015 by the DON or designee on revising resident care plans and use of the care plans.</p>	

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F 280	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to update care plans for: *Two of two sampled residents (10 and 11) receiving hemodialysis (a procedure where a machine filters impurities from your blood when your kidneys cannot). *Two of eleven sampled residents (2 and 3) after a fall with a fracture. *Social service interventions and care needs for one of eleven sampled residents (1). Findings include:</p> <p>1. Record review for residents 10 and 11 revealed: *They both received hemodialysis. *Both resident's had fistulas (a surgical connection made between an artery and a vein used for dialysis). *Both had no mention of daily fistula checks on their care plans to monitor for bruit (the sound a fistula makes when heard through a stethoscope) or thrill (pulsing sensation felt from the fistula).</p> <p>Interview and record review on 2/26/15 at 1:20 p.m. with the assistant director of nursing (ADON) regarding the monitoring of the above residents' fistulas revealed: *Staff would monitor the fistula on days when the residents returned from dialysis but not on days when no dialysis was scheduled. *She agreed in order to accurately monitor the fistulas to ensure they were still working they would need to be checked daily and should have</p>	F 280	<p>The MDS coordinator or designee will complete written audits weekly x4, then monthly x 3 on revising care plans to reflect current status. A minimum of 3 residents will be included in each audit.</p> <p>4. Results of the written audits will be taken the facility QAPI committee monthly by the MDS coordinator or designee for review and recommendations.</p>	4-17-15
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F 280	<p>Continued From page 18 been checked by nursing staff.</p> <p>Interview and policy review on 2/26/15 at 3:15 p.m. with the Minimum Data Set (MDS) assessment coordinator, the director of nursing (DON), and the consulting director of clinical services regarding residents 10 and 11 revealed: *The DON was unaware daily fistula checks had not been added to their care plans. *The MDS coordinator stated she thought that checks were addressed in the provider's undated Emergency Care Measures for Dialysis Resident's policy. *In review of that policy an absence of a bruit or thrill would result in immediate notification of the hospital dialysis department. *The DON agreed in order to assess if there were to be an absence of a bruit or thrill the fistulas would need to be checked. *She agreed it should have been care planned for nursing staff to do that daily.</p> <p>2. Observation and interview on 2/25/15 at 9:50 a.m. with registered nurse (RN) F as she performed a dressing change to resident 3's left ankle revealed: *The resident was positioned on her left side when we entered the room. *The RN grabbed the resident's left foot and pulled her leg upward approximately six inches, so she had access to her outer ankle. *The resident said "ouch" and grimaced as that position caused her pain. *She proceeded to remove the soiled dressing and replaced it with a new dressing. *She then set the resident's leg back down on the bed. *Once outside the room when asked why she had not repositioned the resident on her right side, so</p>	F 280		
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F 280	<p>Continued From page 19</p> <p>she would not have to pull her leg upward, she agreed she should have positioned her on her right side.</p> <p>*She stated she should have appropriately repositioned her on her right side during the dressing change.</p> <p>*RN F had been employed with the facility since November 2014.</p> <p>Review of resident 3's medical record revealed:</p> <p>*She had fallen and fractured her left hip in September 2014.</p> <p>*Her care plan made no mention of the fracture.</p> <p>Interview and policy review on 2/26/15 at 3:15 p.m. with the MDS coordinator, the DON, and the consulting director of clinical services regarding resident 3 revealed:</p> <p>*The MDS coordinator updated the care plan for the resident as needed.</p> <p>*She stated there were interventions on her care plan following her left hip fracture.</p> <p>*When she would change a care plan she would not discontinue interventions listed. She would have edited them and deleted what was not necessary.</p> <p>*They had no documentation in the medical record regarding the care plan that showed there had been interventions in place to alert staff to needed precautions with positioning and her left hip fracture.</p> <p>Surveyor: 32331</p> <p>3. Review of resident 2's revised 2/24/15 care plan revealed:</p> <p>*She had a diagnosis that included dementia.</p> <p>*She had a urinary catheter (tube placed in the bladder to drain urine) put in 2/23/15.</p>	F 280		

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F 280	<p>Continued From page 20</p> <p>*She was at risk for falls due to:</p> <ul style="list-style-type: none"> -Medications. -Unsteady gait (the way a person moves). -Limited range of motion to her left upper arm per the physician's order. -Altered mental (thinking) status. <p>*A goal was to remain free from injury related to falls.</p> <p>*Interventions included:</p> <ul style="list-style-type: none"> -Assist resident to bathroom upon rising, before and after meals, bedtime, and as needed. -Attempt to redirect resident when restless and/or agitated. -Full side rails up when in bed. -Mobility alarm (a personal alarm that sounds with movement) in chair. <p>*Ensure resident had her call light and encouraged to call for assistance before attempting to transfer herself or ambulate (walk) on her own.</p> <p>*Ensure adequate lighting in the room.</p> <p>*Staff to stay with her when she was in the bathroom.</p> <p>*There were no resident specific interventions that addressed:</p> <ul style="list-style-type: none"> -How to effectively get her to use the call light if she was confused. -How her toileting schedule would have changed with the placement of the urinary catheter. -How often she was to have been repositioned. <p>Interview on 2/26/15 at 6:30 p.m. with the MDS (Minimum Data Set) assessment coordinator regarding resident 2's falls revealed:</p> <p>*A safety committee consisting of the MDS coordinator, maintenance supervisor, a certified nursing assistant or a nurse, housekeeping supervisor, a hospitality aide, and the director of nursing met monthly to discuss all falls.</p>	F 280			

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F 280	Continued From page 21 *She stated the written care plan goal was for the resident to remain free from injury related to falls. *That above written care plan goal had not addressed a prevention or a specific reduction of falls. Review of the provider's August 2014 Care Planning policy revealed: *Individual, resident-centered care planning was to have been maintained by the interdisciplinary team. *Care planning was to have been a constant process. *The interventions (any act that implements the care plan or any specific objective of that plan) act as the means to have met the individual's needs. *It was to have been the responsibility of all direct care members to familiarize themselves with the care plans and review them routinely for changes. Refer to F323, finding B. Surveyor: 32335 4. Review of resident 1's 1/26/15 care plan revealed they had not updated the care plan to include psychological recommendations, social service interventions, or care for the nephrostomy tubes (a small rubber tube that is placed through a hole in the skin that extends into the kidney). Review of the provider's April 2013 Care Planning Process policy revealed care plans should have been periodically reviewed and revised.	F 280			
F 281	Refer to F250, finding 2. 483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281			

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F 281 SS=E	<p>Continued From page 22</p> <p>PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 A. Based on observation, interview, record review, and policy review, the provider failed to: *Appropriately assess, monitor, and intervene for 1 of 1 sampled resident (11) with risk for self-harm. *Notify appropriate staff and update the care plan for 1 of 1 sampled resident (3) that required pressure relieving devices when supplies were depleted and needed to be reordered. *Update the electronic medication administration record (MAR) when the route of medication administration had changed for 1 of 1 sampled resident (21). *Clarify a physician's order for one of one observed eye medication bottle found in the 100 unit medication cart for 1 of 14 sampled residents (7). Findings include:</p> <p>1. Observation and interview on 2/24/15 at 9:00 a.m. during the initial tour with resident 11 revealed: *She was propelling herself in her wheelchair down the 100 wing. *She was wearing a hospital style red "ALLERGY" band on her right wrist and had a cotton ball covered in paper tape on her right inner forearm by her elbow. *When asked if she had been in the hospital recently she said she had just returned early that</p>	F 281	<p>F281 Professional Standards</p> <p>1. Residents #11, 3, 21 & 7 are unable to corrected for past non-compliance.</p> <p>2. All residents are potentially at risk.</p> <p>3. All nursing staff and IDT members will be in-services on or before April 17th, 2015 by the DON or designee on Professional Standards, including assessing, monitoring and intervening on resident conditions, updating staff and care plans with resident changes, accurate medical records and clarifying physician orders.</p> <p>The DON or designee will complete written audits on professional standards, including assessing, monitoring and intervening on resident conditions, updating staff and care plans on changes in cares,</p>	

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F 281	<p>Continued From page 23 morning.</p> <p>*She stated she had done "a bad thing."</p> <p>*Further questioning revealed she had stolen from another resident and as a result she had "tried to kill herself."</p> <p>*Nursing staff had sent her to the hospital for a psychological evaluation for the thoughts of suicide. She returned a "couple of hours later."</p> <p>*She stated she was upset, because the staff told her she had thirty days to find a place to live. She stated she had no where to go.</p> <p>Review of resident 11's interdisciplinary progress notes in the medical record revealed:</p> <p>*On 2/23/15 at 6:17 p.m.:</p> <p>- "The resident had reported making comments about hurting herself to the certified nursing assistants (CNA) and the nurse."</p> <p>- She reported she had done "something bad. I need help."</p> <p>- She was sent to the hospital emergency room for evaluation.</p> <p>- The primary physician was notified of the transfer at that time.</p> <p>*At 11:30 p.m. that same day:</p> <p>- She returned from the hospital.</p> <p>- Nursing staff asked the resident what the physician said to her.</p> <p>- She replied to the nurse "They told me I am not crazy, and that I have deep-rooted emotions."</p> <p>*The nursing progress notes above made no mention of her hospital discharge instructions or interventions that should have been implemented for her safety.</p> <p>*From the time she returned from the hospital there was no documentation by the nursing staff of her mental status or any interventions that should have been implemented for her safety.</p>	F 281	<p>updating MARs and physician orders with changes and clarifying physician orders as needed. A minimum of 3 residents will be included in each audit.</p> <p>4. Results of the written audits will be taken to the facility QAPI committee monthly by the DON or designee for review and recommendations</p>	4-17-15

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F 281	<p>Continued From page 24</p> <p>Review of resident 11's 2/23/15 discharge instructions revealed:</p> <ul style="list-style-type: none"> *A clinical diagnosis of suicidal thoughts and depression. *A detailed explanation of suicide that included: <ul style="list-style-type: none"> - "Women purposefully injure themselves more often than men. - Suicide rates are higher as people age. - Those at higher risk for committing suicide are depressed or have mental illness. - An older adult who attempts suicide is much more likely to be successful than a younger person. - In nursing homes, passive suicide by refusing foods or fluids is fairly common. It is often not recognized as a suicidal act. - Most people do NOT hurt themselves or fake suicide just to get attention. - If someone tells you he or she is planning to commit suicide, take it seriously. - Remove or lock up lethal weapons such as guns, pills, and ropes. - Do not leave the person alone." *Specific instructions labeled 1, 2, and 3 were documented as follows: <ul style="list-style-type: none"> - "1. Follow up with your doctor tomorrow for further management. - 2. Return if worsening symptoms, increased pain, suicidal thoughts or plan, or other concerns. - 3. Continue medications as previously directed." <p>Interview and record review on 2/26/15 @ 9:55 a.m. with the assistant director of nursing (ADON) regarding resident 11's suicidal threats and the follow-up documentation revealed:</p> <ul style="list-style-type: none"> *The process would have been to notify the social worker, the consultant mental health provider, and the primary physician after the suicidal threat or a suicide attempt by a resident. 	F 281		

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F 281	<p>Continued From page 25</p> <p>*She was unable to find any documentation to support nursing staff had provided monitoring of the resident, notification to staff, and interventions that were implemented to protect the resident at risk for self harm.</p> <p>*Regarding the documentation she stated "I cannot say it was done because it is not documented. We should have documented."</p> <p>Interview and record review on 2/26/14 at 3:15 p.m. with the director of nursing (DON) and the director of clinical services consultant regarding resident 11 revealed they:</p> <p>*Agreed there were no interventions documented on the care plan after she had returned from the hospital regarding her suicidal thoughts and risk for self-harm until after 5:00 p.m. on 2/25/15. That was fourteen hours after her return.</p> <p>*Agreed that was the expectation of nursing and or social services would place interventions on behalf of any resident deemed at risk for self-harm or suicide when they had returned from the hospital.</p> <p>*Did not believe the resident was serious about her thoughts of self-harm.</p> <p>*Agreed there had been no documentation that anyone had checked on the resident or spoken with her.</p> <p>*Had not put into place the interventions listed on the discharge instructions sheet that was received from the hospital. They had not considered it a signed order.</p> <p>*Were unaware nursing staff had documented they were aware of the instructions, as they had noted and timed them on 2/24/15 at 5:45 a.m.</p> <p>*Agreed there should have been communication between departments.</p> <p>*Agreed interventions should have been put in place immediately following her re-admission</p>	F 281			

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F 281	<p>Continued From page 26 from the hospital.</p> <p>*Agreed they would expect staff to consult the provider's policy regarding suicide for guidance.</p> <p>Review of the provider's 2010 Suicide Threats policy revealed staff "will monitor the resident's mood and behavior and update the care plan accordingly."</p> <p>Review of the provider's August 2013 Suicide Precautions policy revealed staff were to have: *Removed all equipment that could have been used and/or that would cause harm. *Notified social services to inform him or her of the incident. *Documented events and updated the care plan. *"If there is no plan for suicide, the care plan needs to be updated to find out if the resident would comment about "wanting to die" and each time an assessment will be completed to assure there is no plan."</p> <p>Review of the provider's 2013 Suicide Precautions checklist revealed staff were to have: *Removed all potentially dangerous articles from the resident's room. *There was to have been checks at ten, fifteen or thirty minutes, an hour, every two hours, or every shift depending on the order. *A note at the bottom of the page required staff to start a separate flowsheet to document the resident's location and activity at the intervals listed above. *Kept the flowsheet in the medication administration record (MAR) or in an area easily accessible to all staff assigned to monitor the resident. *Used the flow sheet until the team had determined checks were no longer necessary.</p>	F 281			

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F 281	<p>Continued From page 27</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 279, revealed: **Following the identification of a patient's diagnoses and problems, you: -Develop a plan of care. -Implement nursing interventions. -Evaluate patient outcomes. *This process requires clinical decision making using a critical thinking approach. *If you do not make accurate clinical decisions about a patient, undesirable outcomes will probably occur."</p> <p>Refer to F250, finding 1.</p> <p>2. Random observations on 2/24/15 from 8:00 a.m. through 2/26/15 at 10:00 a.m. of resident 3 regarding her Prevalon (pressure relieving) heel protecting boots that were to be worn on both feet revealed: *She was seen multiple times throughout the day on 2/24/14 and had not been wearing the Prevalon boots. *Her care plan documentation showed she was to wear bilateral heel protectors. *On 2/25/15 she was seen multiple times throughout the day wearing a Prevalon heel protector on her left heel and a non-skid sock on her right foot. *On 2/26/15 at 8:15 a.m. she was seen wearing the a smaller non-Prevalon heel protector on her left foot, and a non-skid sock on the right foot.</p> <p>Interview on 2/26/15 at 10:20 a.m. with the Minimum Data Set (MDS) coordinator in her office regarding resident 3's care planned Prevalon boots revealed:</p>	F 281		

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F 281	<p>Continued From page 28</p> <p>*She thought the resident was wearing her boots on 2/24/15.</p> <p>*She had sent the boots to be washed in on 2/25/15.</p> <p>*The padding had become warped on the right foot boot. She had discarded that Prevalon boot and ordered a new one for her right foot.</p> <p>*She stated she had older smaller heel protectors available that she had advised staff to use on the resident's right heel until a new Prevalon boot had arrived.</p> <p>*She was unaware the resident was only observed wearing the older smaller heel protector on only the left foot the day earlier, and had not been wearing the larger Prevalon boot.</p> <p>*She agreed the resident was wearing the smaller heel protector on the left foot, and that her left Prevalon boot was missing.</p> <p>*She stated she would alert Hospice of the missing boots.</p> <p>*She had not notified staff the right Prevalon boot had needed replacement nor had she updated the care plan to reflect the change.</p> <p>*She agreed staff would have no way of knowing the right Prevalon boot had needed replacement. She had not advised them of the change nor updated her care plan.</p> <p>*She agreed she should have communicated changes with staff when the resident's care would be affected.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 262, revealed, "Unless communication is timely and accurate, caregivers can be uninformed, interventions may be duplicated needlessly, procedures may be delayed, or tasks may be left undone."</p>	F 281			

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F 281	<p>Continued From page 29</p> <p>3. Review of resident 21's medical record revealed:</p> <p>*He had eighteen medications ordered to be given through his gastrostomy (G-tube) (tube inserted directly into the stomach to provide medications and nutrition).</p> <p>*He had one medication ordered to be given by mouth.</p> <p>*The resident would often refuse medications or flushes through his G-tube.</p> <p>*Staff had requested an order from the physician on 10/1/14 to take medication by mouth or through his G-tube into his stomach.</p> <p>*The resident's physician had faxed an order dated 10/1/14 that he approved the resident would be able to choose to take his medications either orally or through his G-tube.</p> <p>*Nursing staff had noted the order seven days later on 10/8/14.</p> <p>*His medication administration record was never updated to reflect the change of giving his medications orally or enterally.</p> <p>Interview on 2/26/15 at 9:55 a.m. with the ADON regarding resident 21's medications revealed: *"He has some medications that taste bad. We can give them through the G-tube rather than orally if he doesn't want to take them that way." *She agreed nursing staff should have updated the eMAR (electronic medication administration record) to reflect the resident's new order to take his medications orally or enterally.</p> <p>Interview and record review on 2/26/14 at 3:15 p.m. with the DON and the director of clinical services consultant regarding resident 21's eMAR revealed it was their expectation that nursing staff should have been viewing the eMAR for accuracy before a medication was given. Nursing staff</p>	F 281			

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F 281	<p>Continued From page 30 should have been reconciling the eMAR with the current physician's order.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 590, revealed: **If the medication order is incomplete, incorrect, or inappropriate or if there is a discrepancy between the original order and the information on the MAR, consult with the prescriber. *Do not give medication until you are certain that you can follow the six rights of medication administration."</p> <p>4. Random observation and interview with certified nursing assistant (CNA)/medication aide M during the medication cart review on the 100 wing revealed: *One bottle of prednisolone (a steroid) eye drops that belonged to resident 7. *Administration instructions printed on the bottle were to "administer one drop to the right eye after surgery, then four times per day for seven days, then two times per day until gone." *The CNA confirmed it was half full. *She stated the resident had no longer received the drops. They were discontinued on the eMAR, but she had been unsure when.</p> <p>Review of the medical record for resident 7 revealed: *A postoperative progress note from the surgeon dated 1/14/15 at 1:20 p.m. documented: "Uneventful cataract surgery. Shield (eye cover) through tonight. Drops as previously instructed." *A postoperative progress note from the surgeon dated 1/19/15 at 2:55 p.m. documented: "Doing well following cataract surgery to right eye. Continue prednisolone twice daily to right eye as</p>	F 281		

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F 281	<p>Continued From page 31 previously directed." *Eye Medication Instructions For Cataract Surgery that had accompanied the resident when she returned to the facility after her right eye cataract surgery, noted by facility nursing staff on 1/15/15 stated "After surgery, use 1 drop (prednisolone) in the operative eye, 4 times daily for one week, then two times daily for 3 weeks." *Those instructions had not been signed by the surgeon, but they considered them to be signed orders.</p> <p>Interview on 2/26/15 at 1:48 p.m. with consultant pharmacist N regarding the above prednisolone eye drops for resident 7 revealed: *The order the pharmacy had on file matched the instructions that had been written on the bottle. *He would fax a copy of the written orders he had received from the physician who performed the surgery to the facility for review by this surveyor. *His expectation of staff would be to clarify with the physician if there was a discrepancy with the order.</p> <p>Review of resident 7's 11/10/14 signed physician's order for the above prednisolone drops revealed: *They had been given to the facility and then faxed to the consulting pharmacy on 1/6/15 by the facility. *Directions were to "administer one drop in the right eye four times per day four days before surgery, then four times per day for one week then twice daily until gone."</p> <p>Interview and record review on 2/26/14 at 3:15 p.m. with the DON and the director of clinical services consultant regarding prednisolone drops for resident 7 revealed:</p>	F 281		

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F 281	<p>Continued From page 32</p> <p>*They considered the Eye Medication Instructions For Cataract Surgery the current physician's order.</p> <p>*They stated their expectation would be discrepancies in physician's orders would be clarified by nursing staff with the prescribing physician.</p> <p>Review of the provider's June 2013 Physician Medication Orders policy revealed "All drug orders shall be written, dated and signed by the person lawfully authorized to give such an order."</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 590, revealed "If the medication order is incomplete, incorrect, or inappropriate or if there is a discrepancy between the original order and the information on the MAR, consult with the prescriber."</p> <p>Surveyor: 32331</p> <p>B. Based on observation, interview, record review, and policy review, the provider failed to:</p> <p>*Appropriately assess, monitor, and intervene for one of six sampled residents (2) with Type II diabetes whose blood sugar levels had fallen below 60. Findings include:</p> <p>1. Review of resident 2's medical record revealed:</p> <p>*An admission date of 5/16/13.</p> <p>*Diagnosis that included diabetes (a disease that affects how the body uses blood sugar or glucose).</p> <p>*A physician's order on 2/19/14 "...four times a day for blood sugar."</p> <p>*Those blood sugars were scheduled to be</p>	F 281		

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F 281	<p>Continued From page 33</p> <p>checked at 8:00 a.m., noon, 5:00 p.m., and at 8:00 p.m.</p> <p>*A physician's order on 12/23/14 for a "Glucagon Emergency Kit 1 mg [milligram] (Glucagon (rDNA) [a medicine given by injection (shots) to treat severe hypoglycemia (low blood sugar)] Inject 1 mg intramuscularly (into the muscle) as needed for low BS [blood sugar]."..."to be given when BS [blood sugar] is less than 60 or symptomatic [showing symptoms]."</p> <p>Review of resident 2's 12/1/14 through 2/24/15 MARs (medication administration record) revealed:</p> <p>*Blood sugar levels were not documented:</p> <ul style="list-style-type: none"> -On 12/3/14 at 8:00 p.m. -On 12/23/14 at 5:00 p.m. -On 1/13/15 at 5:00 p.m. -On 2/4/15 at 8:00 p.m. <p>*On 2/22/15 at 5:00 p.m. she had a 54 mg/dl (milligrams/deciliter) blood sugar reading.</p> <ul style="list-style-type: none"> -The above reading was less than 60 mg/dl. -That reading would have required the Glucagon medication or if the resident had been symptomatic. <p>Review of resident 2's nurse's notes revealed:</p> <p>*There was no documentation why the blood sugar readings were not obtained on the above listed dates and times.</p> <p>*On 2/22/15 at 5:35 p.m. registered nurse (RN) F had documented:</p> <ul style="list-style-type: none"> -"Refused lunch after insulin being given. Blood sugar 54 before supper. Refuses supper pills. Supper 8 units Novolog [a fast-acting insulin used to control high blood sugar in people with diabetes] held. Dr [Doctor] _____ faxed to let know of low blood sugar refusal to eat lunch." -There was no documentation of a nursing 	F 281		

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F 281	<p>Continued From page 34</p> <p>assessment regarding resident's symptoms at the above time.</p> <p>-There was no documentation the Glucagon medication had been received by the resident with the blood sugar level less than 60 mg/dl.</p> <p>*On 2/22/15 at 10:33 p.m. RN G had documented her blood sugar level was 114 mg/dl.</p> <p>-On 2/22/15 from 5:35 p.m. until 10:33 p.m. there was no documentation regarding her blood sugar levels or symptoms.</p> <p>Review of resident 2's revised 2/24/15 care plan revealed:</p> <p>*She had a diagnosis that included diabetes.</p> <p>*She was on insulin.</p> <p>*She was at risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar).</p> <p>*Her blood sugars fluctuated (to vary irregularly).</p> <p>*Interventions had included:</p> <p>-Blood sugars as ordered.</p> <p>-See physician's orders and the MAR.</p> <p>Interview on 2/26/15 at 2:45 p.m. with the director of nursing (DON) and the director of clinical services regarding resident 2 revealed:</p> <p>*Residents with low blood sugars were reported at stand-up (a daily meeting with staff) .</p> <p>*Nursing was to have been given her the Glucagon medication with a blood sugar level less than 60 mg/dl or if she had been symptomatic.</p> <p>Interview on 2/26/15 at 3:45 p.m. with the DON regarding resident 2 revealed:</p> <p>*She confirmed it had not been documented why the Glucagon medication had not been given.</p> <p>*She stated if she had been symptomatic, that had needed to have been assessed by the nurse and documented.</p>	F 281		

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F 281	<p>Continued From page 35</p> <p>Review of the provider's 2013 Diabetes Clinical Protocol revealed: **The physician will order desired parameters [a set of measurable factors, such as blood sugar levels] for monitoring and reporting information related to diabetes or blood sugar management." *The staff were to have incorporated such parameters into the MAR and the care plan.</p> <p>Review of the provider's 2013 Insulin Administration policy revealed "Notify the physician if the resident has signs and symptoms of hypoglycemia that are not resolved by following the facility protocol for hypoglycemia management."</p> <p>Review of the provider's revised August 2013 Physician Services policy revealed the medical care of each resident was under the supervision of a licensed physician.</p> <p>Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing 8th Ed., St. Louis, Mo., 2013, p. 305, revealed "The health care provider (physician or advanced practice nurse) is responsible for directing medical treatment."</p> <p>Todd P. Semla et al., Geriatric Dosage Handbook, 16th Ed., American Pharmacists Association, Hudson, Ohio, 2011, p. 2006, revealed the before meal blood sugar level laboratory value range was 70-130 mg/dl.</p> <p>Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, pp. 206-208 and p. 1023, revealed: **The nursing process is a critical thinking process that professional nurses use to apply the</p>	F 281		

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F 281	Continued From page 36 best available evidence to caregiving and promoting human functions and responses to health and illness." *"Assessment is the deliberate and systematic collection of information about a patient to determine his or her current and past health and functional status." *"The purpose of the assessment is to establish a database about patients perceived needs, health problems, and responses to these problems." *Hypoglycemia signs and symptoms had included sweating, shakiness, confusion, and loss of consciousness.	F 281			
F 323 SS=E	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: 32335 A. Based on observation, measurement, interview, and policy review, the provider failed to ensure side rails had been assessed for safety and entrapment (getting caught in) risk for seven of seven beds that had arrived in the facility on 7/2/14. Findings include: 1. Observations on 2/24/15 from 8:15 a.m. through 9:20 a.m. and again on 2/25/15 at 10:40 a.m. revealed seven beds with metal side rails.	F 323	F323 Accident Hazards 1. 7 of 7 beds with metal side rails were addressed on February 25 th , 2015 by facility associates. All metal side rails on these 7 beds were removed and disposed of on this date. Resident #2 will be re-assessed for appropriate fall interventions on or before April 17 th , 2015. 2. All staff will be educated on or before April 17 th , 2015 on side rails / enablers and the risk for entrapment. Also included in this in-service will be bed check systems for beds arriving at the facility, to assure they are safe and in good repair.		

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F 323	<p>Continued From page 37</p> <p>The side rails had five bars between each end. The measurements between the bars were 5 3/4 inches and 7 1/2 inches. Those gaps were large enough for a resident's head or other body part to get entrapped.</p> <p>Interview on 2/25/15 at 10:40 a.m. with the director of nursing and the nurse consultant revealed:</p> <ul style="list-style-type: none"> *They followed the Guidance for Industry and Food and Drug Administration (FDA) Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment recommendations for all side rails. *They were unaware the beds had those metal side rails. *The gaps between the bars were too large and were a safety concern. *For safety purposes the gaps should have been no larger than 4 3/4 inches. *The beds came into the facility on 7/2/14 from another facility. *The maintenance man should have assessed the beds for safety when they had arrived in the facility. <p>Interview on 2/25/15 at 11:30 a.m. with the nurse consultant revealed all the beds with the metal side rails identified above had been replaced.</p> <p>Review of the provider's January 2014 Bed Safety policy revealed they should have assessed the gaps between the side rails to determine if they followed the FDA guidelines.</p> <p>Surveyor: 32331 B. Based on record review, interview, and policy review, the provider failed to ensure appropriate</p>	F 323	<p>The Administrator or designee will complete written audits weekly x 4, then monthly x 3 on side rails / enabler device safety and post fall interventions on residents who have had a fall.</p> <p>4. Results of the written audits will be taken the facility QAPI committee monthly by the Administrator or designee for review and recommendations.</p>	4-17-15

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F 323	<p>Continued From page 38</p> <p>interventions were put in place to prevent falls with major injury for one of two sampled residents (2) who had multiple falls. Findings include:</p> <p>1. Review of resident 2's medical record revealed: *An admission date of 5/16/13. *Diagnoses included dementia (memory problems), chronic (long duration) pain, and depressive disorder (an illness that involves body, mood, and thoughts). *She was on multiple medications. *A physician's order on 8/31/14 for a "Geriatric [elderly] chair and side rails on bed at nursing facility. Family requesting. Pt [patient] with history of falls resulting in injuries."</p> <p>Review of resident 2's nurses notes revealed: *She had sixteen falls in her room from 2/26/14 through 12/23/14. *Two of those sixteen falls had resulted in major injuries on 8/10/14 and 8/18/14. *On 8/10/14 at 11:08 p.m. by registered nurse (RN) K: -She fell in her room unwitnessed at 10:30 p.m. -She was found on her left side at the foot of her bed. -She complained of pain in left upper arm. *That fall on 8/10/14 had resulted in a broken humerus (the long bone in the arm from shoulder to the elbow) and required surgery on 8/12/14. *On 8/18/14 at 7:11 a.m. by RN L: -She fell in her room unwitnessed at an undocumented time. -She had been attempting to get to the commode by herself. *That fall on 8/18/14 had resulted in a dislocated shoulder and required surgery on 8/27/14.</p>	F 323			

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F 323	<p>Continued From page 39</p> <p>Review of resident 2's 2/27/14 through 9/17/14 Post Fall Assessments revealed the following new interventions were added:</p> <ul style="list-style-type: none"> *Gripper socks needed to be on resident when no shoes were on. *Staff were to have stayed in the bathroom with her. *She was to have been reminded to use her call light and wait for help. *Respond to her room quickly when she was talking loudly and was agitated (upset). *Frequent checks of her any time she was in her room. *Possible re-check of an urinary analysis (a laboratory test of the urine) for urinary frequency. *Resident was to have been checked on every thirty minutes to see if she needed to use the toilet. *Ensure her blanket was not down around her ankles. *Ensure the TABS (a type of personal alarm that sounds with movement) monitor was on. *Monitor sensor (an alarm that monitors movement) bed alarm was on when she was in bed. <p>Further review of the above Post Fall Assessments revealed there was no evidence they had evaluated and /or investigated the following:</p> <ul style="list-style-type: none"> *When was the last time she had been toileted? *When was the last time she had been repositioned? *What medications could have contributed to the fall? *How long had she been in her bed or wheelchair? *Was her call light within reach each time? *Was she in pain prior to the fall and was that why 	F 323		

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F 323	<p>Continued From page 40 she was attempting to reposition herself?</p> <p>Review of resident 2's 8/1/14 Minimum Data Set (MDS) quarterly assessment sections B, C, G, and H revealed she:</p> <ul style="list-style-type: none"> *Was able to express her ideas and wants. *Had the ability to understand others. *Had a Brief Interview for Mental Status (a test that helps determine a resident's cognitive [thinking] understanding) score of 6 that indicated severe impairment or loss. *She had needed extensive assistance (staff providing weight-bearing support) with one person physical assist for: <ul style="list-style-type: none"> -Bed mobility. -Transfer. -Walking in room and corridor. -Locomotion (moving from one place to another) on and off the unit. -Dressing. -Toilet use. -Personal hygiene. -Bathing. *Her balance during transitions and walking was not steady for: <ul style="list-style-type: none"> -Moving from a seated to standing position. -Walking. -Turning around. -Moving on and off the toilet. -Surface-to-surface transfer (transfer between bed and chair or wheelchair). *She had been on a toileting program. <p>Interview on 2/24/15 at 3:35 p.m. with certified nursing assistant H regarding resident 2 revealed she:</p> <ul style="list-style-type: none"> *Had a history of falls. *Had been hospitalized after two falls in August 2014. 	F 323		

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F 323	<p>Continued From page 41</p> <p>*Was able to follow directions. *Needed to be cued (reminded) to reposition herself.</p> <p>Interview on 2/25/15 at 9:00 a.m. with the director of nursing (DON), the director of clinical services, the administrator, and the MDS coordinator regarding resident 2's falls revealed: *She had a history of falls. *She was a fall risk. *Her falls had decreased significantly since the placement of the bilateral (both sides) side rails on both the upper and lower portions of the bed. *The above side rails had been placed on her bed on 8/31/14 per physician's order.</p> <p>Interview on 2/26/15 at 1:15 p.m. with the DON and the director of clinical services regarding resident 2's falls revealed: *Her falls would have been reported at stand-up (a daily meeting with staff). *Falls were discussed at monthly quality assurance meetings.</p> <p>Review of the provider's revised October 2014 Falls Prevention policy received from the DON revealed: *Residents who were at high risk for falls were to have been identified. *Individual precautions were to have been developed to prevent further falls for identified residents. *A checklist for minimizing the risk for falls that included: -Collect and analyze data. -Identify factors related to falls: what were they trying to do or what did they want? Can we determine a pattern? -Correct or minimize risk factors where possible.</p>	F 323		

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F 323	Continued From page 42 -Conduct fall assessments. -Identify residents at risk for falling. -Alert all staff to residents at high risk of falling. -Develop, implement, and carry out a plan to prevent falls. -Involve the resident in the development of the plan for the prevention of falls. -Involve the family in the resident's plan. -Revise the care plan as required based on the resident's needs. -Communicate the plan with staff."	F 323	F332 Medication Errors 1. Resident #6, 13, 4, & 14 noted in the 2567 are unable for past non-compliance. 2. All residents are at risk. 3. All nurses will be educated on or before April 17th, 2015 by the DON or designee on Medication Administration, including but not limited to, insulin pen use and administration, and specific times scheduled for select medications, such as Prilosec. The DON or designee will complete written audits on Medication administration weekly x 4, then monthly x 3. A minimum of 3 residents will be reviewed with each audit. 4. Results of the written audits will be taken to the facility QAPI committee by the DON or designee monthly for review and recommendations.	
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, policy review, and manufacture's guideline review, the provider failed to: *Appropriately administer insulin according to manufacturers' guidelines for three of twenty six observed medication administrations for residents 4, 6, and 13. *Appropriately administer Prilosec (acid reflux medication) as ordered for 1 of 26 resident's (14) medication administration. *Ensure a medication error rate had not exceeded 5 percent (%) of the total twenty-six medication administration observations. Findings included: 1a. Observation on 2/25/15 at 7:35 a.m. of	F 332		

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F 332	<p>Continued From page 43</p> <p>registered nurse (RN) F administering 25 units of insulin from a Novolog Flex pen to resident 6 revealed:</p> <p>*She removed the pen from the drawer and attached the needle without cleansing the rubber stopper with an alcohol pad.</p> <p>*She primed the insulin pen as follows. She:</p> <ul style="list-style-type: none"> -Dialed the pen to one unit. -Had not removed the outer needle cap. -Proceeded to hold the pen side-ways and depressed the bottom on the pen. -Dialed the pen to twenty-five. -Pulled off the outer cap on the needle. -Wiped the resident's right lower abdomen with an alcohol wipe. -Administered the insulin and immediately removed the needle from the resident's skin. -Documented the administration in the electronic medical record. <p>b. Observation on 2/25/15 at 7:45 a.m. of RN F administering twenty-five units of insulin from a Novolog Flex pen to resident 13 revealed:</p> <p>*She removed the pen from the drawer and attached the needle without cleansing the rubber stopper with an alcohol pad.</p> <p>*She primed the insulin pen as follows. She:</p> <ul style="list-style-type: none"> -Dialed the pen to one unit. -Had not removed the outer needle cap. -Proceeded to hold the pen side-ways and depressed the bottom on the pen. -Dialed the pen to twenty-five. -Pulled off the outer cap on the needle. -Wiped the resident's left lower abdomen with an alcohol wipe. -Administered the insulin and held the needle in place for six seconds. <p>c. Interview on 2/25/15 at 7:55 a.m. with RN F</p>	F 332		

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F 332	<p>Continued From page 44 regarding the above insulin administrations revealed:</p> <p>*When asked what she would use for reference in using the Novolog flexpen she stated she had read the protocol book in the chart room located between the 100 and 200 wing and would review it monthly.</p> <p>*She stated proper use of the pen included priming it with one unit.</p> <p>*She was unaware two units of insulin were required to have been used with the Novolog flexpen to prime it according to manufacturer's guidelines.</p> <p>*She had not received formal training from the provider on proper use of the flexpen since she had been hired in November 2014.</p> <p>*The book she had referred to was a standing order book and had no reference material regarding the use of insulin pens.</p> <p>*She was unsure where to go for information on proper use.</p> <p>d. Observation and interview on 2/25/15 at 4:55 p.m. with RN O administering insulin from a Novolog flexpen to resident 4 revealed:</p> <p>*She administered it on the lateral side of his left arm into his deltoid muscle.</p> <p>*She was unaware it should have been administered into his posterior (rear) part of his arm into the subcutaneous (fat) tissue for proper absorption.</p> <p>e. Review of the 2015 manufacturer's guidelines for the Novolog flexpen revealed proper administration steps were as follows:</p> <p>*"Remove the pen cap.</p> <p>*Wipe the rubber stopper with an alcohol swab.</p> <p>*Attach the needle.</p> <p>*Remove the protective tab, screws it onto the</p>	F 332			

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F 332	<p>Continued From page 45</p> <p>pen, and pulled off the outer cap. *Turn the dose selector to 2 units. *Hold the pen with the needle pointing up. *Press the bottom in until the dose selector returns to zero. *Turn the dose selector to the number of units needed. *Insert the needle into the skin of the abdomen, buttocks, thigh or upper arm for subcutaneous injection. *Press the button to inject the insulin. *Keep the needle in the skin for at least 6 seconds before removing. *The prescribing dose is not completely delivered until 6 seconds later."</p> <p>Review of the provider's February 2014 Insulin Administration policy stated "The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery systems prior to their use."</p> <p>2. Observation on 2/25/15 at 5:15 p.m. with RN L administering Prilosec 20 milligrams once daily to resident 14 during the evening meal revealed the physician's order stated the medication was to have been given one hour prior to the largest meal of the day.</p> <p>3. The above four medication errors were a total of four medication errors out of twenty-six observed medication administrations for a medication error rate of 15.38%.</p> <p>Interview and record review on 2/26/15 at 3:15 p.m. with the director of nursing and the director of clinical services consultant regarding the above insulin and Prilosec administrations revealed: *It was their expectation nursing staff would</p>	F 332		

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F 332 F 364 SS=E	<p>Continued From page 46</p> <p>administer medications according to the physicians' orders and manufacturer's guidelines. *It was also their expectation the medication error rate would be below five percent.</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, testing, interview, and policy review, the provider failed to ensure hot food temperatures during one of one breakfast meal observation of a sampled test tray were served at a palatable (acceptable to the palate or taste) and held at an acceptable temperature for 13 of 13 residents receiving room trays. Findings include:</p> <p>1. Confidential interview on 2/24/15 at 3:45 p.m. with a group of residents revealed they could ask for room trays if they wanted to eat in their rooms. The food delivered to the rooms was lukewarm, and it was never hot.</p> <p>Observation on 2/25/15 at 8:20 a.m. with cook A and the certified dietary manager (CDM) in the kitchen revealed: *The provider's calibrated (checked for accuracy) dial food thermometer used by cook A for testing the hot foods in the steam table had the following</p>	F 332 F 364	<p>F364 Nutritional values / temps</p> <ol style="list-style-type: none"> 1.No specific residents are identified in the 2567. 2. All residents receiving room trays are potentially at risk. 3. The Dietary Services Manager will implement insulated bottom plates for room trays, along with insulated covers and prior to dishing, plates are heated though the dishwasher. This new system was implemented 02/26/15 The DSM or designee will complete written audits weekly x 4, then monthly x 3 on room tray temps to assure food is at appropriate temperatures. 4. Results of the written audits will be taken the facility QAPI committee by the DSM or designee monthly for review and recommendations. 	4-17-15

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F 364	<p>Continued From page 47</p> <p>results:</p> <ul style="list-style-type: none"> -Scrambled eggs were at 188 degrees Fahrenheit (F). -Cream of Wheat hot cereal was at 178 degrees F. *From 8:20 a.m. through 8:36 a.m. cook A dished up the food for thirteen residents' room trays for the following locations: <ul style="list-style-type: none"> -Seven residents in the Transitional Care Unit (TCU). -Six residents in the east and west wings. -The TCU room trays were dished up before the room trays for the east and west wings. *At 8:37 a.m. cook A dished up the food for a sample test tray for the surveyor to test the food temperatures. -That sample test tray was covered with an insulated dome lid covering the hot foods. It had been placed on a four-tiered open cart with the six resident room trays for the east and west wings. <p>Continued observation on 2/25/15 from 8:37 a.m. through 8:46 a.m. with certified nursing assistant (CNA) B and the CDM revealed:</p> <ul style="list-style-type: none"> *At 8:37 a.m. CNA B transported the above cart to the south end of the building toward the east and west wings. *At 8:40 a.m. that cart arrived on the west wing and room trays were delivered to four residents. *After the west wing room trays were distributed the east wing room trays were delivered to two residents. *At 8:45 a.m. the last tray was delivered to a resident on the east wing. *At 8:46 a.m. the sample test tray was delivered to the surveyor on the east wing. *That tray was tested using the provider's calibrated dial food thermometer with the 	F 364			

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F 364	<p>Continued From page 48 following results:</p> <ul style="list-style-type: none"> -The scrambled eggs were at 128 degrees F. -The Cream of Wheat hot cereal was at 116 degrees F. *The total time from when the above test tray was dished up to when the last resident was served was a total of eight minutes. *The hot food temperature had decreased in that time frame as follows: <ul style="list-style-type: none"> -The scrambled eggs had decreased 60 degrees F. -The hot cereal had decreased 62 degrees F. *The temperatures of the hot foods should not have been less than 135 degrees F. <p>Interview and taste testing on 2/25/15 at the above time and location with the CDM regarding the sample test tray revealed she stated:</p> <ul style="list-style-type: none"> *The scrambled eggs and hot cereal were not at acceptable hot food temperatures. *The scrambled eggs were "rubbery and overcooked." *The above eggs and cereal were not palatable. <p>Review of the provider's undated Passing Resident Room Trays policy revealed residents were to have received a nutritious and palatable meal delivered to their rooms.</p> <p>Review of the provider's undated Critical Temperatures for Safe Food Handling revealed the minimum hot food holding temperature was to have been 140 degrees F or higher.</p> <p>Review of the provider's undated Food Temperatures Log revealed hot foods were to have been equal to or greater than 165 degrees F prior to trayline and equal to or greater than 135 degrees F through the end of trayline.</p>	F 364		

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F 364	Continued From page 49	F 364		
F 371 SS=F	<p>Review of the provider's undated Food Temperatures policy revealed: *All hot food items would have been held and served at a temperature of at least 140 degrees F. *Temperatures were to have been taken periodically to ensure hot foods stayed above 140 degrees F until received by the resident.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, testing, interview, and policy review, the provider failed to ensure sanitary conditions were maintained for the following in the kitchen: *For the kitchen: *Sanitizing food counters and carts. *Fourteen out of fourteen vents. *One of one fan in the walk-in cooler. *Three of six drawers. *Four of six cupboards. *Four of twenty-four shelves in the dry food storage room.</p>	F 371	<p>F371 Store, Prepare and Serve</p> <p>1.No specific residents are identified in the 2567.</p> <p>2.All residents are potentially at risk.</p> <p>3. a. All kitchen staff will be educated on or before March 19th, 2015 by the DSM or designee on checking and changing the sanitizing bucket every 2hrs or as cold or soiled.</p> <p>b. Vents in the kitchen – all vents in the kitchen were cleaned on March 18th, 2015 and have been added to the kitchen cleaning schedule for ongoing compliance.</p> <p>c. Cupboards in the kitchen – estimates will be obtained by April 17th, 2015 for replacement of those areas not cleanable. Anticipate completion by June 30th, 2015.</p>	

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F 371	<p>Continued From page 50</p> <ul style="list-style-type: none"> *One of one shelf in the dishroom. *One of one plate holder in the dishroom. *One of one cooler floor threshold. *For the Town Square dining room: <ul style="list-style-type: none"> *Microwave. *Four of four stove burner pans. <p>Findings include:</p> <p>1. Observation on 2/24/15 in the kitchen from 8:15 a.m. through 8:58 a.m. revealed:</p> <ul style="list-style-type: none"> *A bucket next to the two compartment sink filled approximately one-fourth full of a clear liquid. <ul style="list-style-type: none"> -That bucket contained one wet cloth. -This surveyor tested the above bucket with a Hydrion QT-40 quaternary (quat) test strip (a type of special paper), and it tested zero parts per million (ppm). -That test strip needed to have tested at least 150 ppm for proper sanitizing strength. *Fourteen ceiling vents had a large build-up of dust and lint on them. <ul style="list-style-type: none"> -Six of those ceiling vents were located above a food production area. *One fan in the walk-in cooler had a large build-up of dust. <ul style="list-style-type: none"> -It was blowing directly over three carts of food stored in the cooler. *Three drawers on the inside had a significant amount of peeling, chipped paint. *Four cupboards on the inside had a significant amount of peeling, chipped paint with one cupboard with chipped, unfinished wood. *Four shelves in the dry goods storage room contained resident food and supplies had a moderate amount of chipped and peeling paint on the shelves. *One shelf in the dishroom contained chemicals had a significant amount of peeling, chipped paint. 	F 371	<p>d. Plate holder was cleaned on March 4th, 2015 and then placed on a weekly cleaning schedule for ongoing compliance.</p> <p>e. Walk in cooler replacement estimates have been obtained and estimated completion date is June 30th, 2015 for completion.</p> <p>f. Microwave was removed from Town Square dining area on February 25th, 2015.</p> <p>g. The stove in the Town Square dining area was cleaned on February 25th, 2015 by the Activity Director and is now on a weekly cleaning schedule to be completed by the Activity Director.</p> <p>h. Dishwashing room shelf was removed and replaced on March 11th, 2015.</p>	

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F 371	<p>Continued From page 51</p> <p>*Those above drawers, cupboards, and shelves were uncleanable surfaces.</p> <p>*One Cambro plate holder in the dishroom had a large amount of tan, brown, and white specks along the sides and crumbs located in the bottom where residents' plates were stored.</p> <p>-That plate holder was located in the clean end of the dishroom.</p> <p>*One cooler floor threshold had a one and one-half inch wide opening filled with debris.</p> <p>*There was a hole approximately three inches by approximately one-half inch in the floor next to the threshold in front of the walk-in refrigerator.</p> <p>-That cooler threshold and floor were no longer cleanable surfaces.</p> <p>Interview on 2/25/15 during the above observation with the certified dietary manager (CDM) and with cook A present revealed:</p> <p>*The CDM stated the bucket located next to the two-compartment sink was "low" and needed to be changed.</p> <p>*The CDM then refilled the bucket with Oasis 146 Multi-Quat Sanitizer from a dispenser on the wall located above the three-compartment sink.</p> <p>Interview on 2/25/15 at 11:10 a.m. with the CDM revealed:</p> <p>*The vents in the kitchen were cleaned by maintenance on an as needed schedule.</p> <p>*They had been last cleaned by the maintenance supervisor who had left in November 2014.</p> <p>*She stated they had not been cleaned since at least November 2014.</p> <p>Observation on 2/24/15 at 11:35 a.m. in the kitchen revealed:</p> <p>*Brown-colored plates were being used by cook A to serve the noon meal.</p>	F 371	<p>Dietary cleaning schedule was reviewed, updated and implemented on March 20th, 2015 by the DSM.</p> <p>All dietary staff will be educated on March 19th, 2015 regarding the new cleaning schedule.</p> <p>DSM or designee will complete written audits on the above noted areas weekly x 4, then monthly x 3</p> <p>4. Results of the written audits will be taken to the facility QAPI committee by the DSM or designee monthly for review and recommendations.</p>	4.17.15

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F 371	<p>Continued From page 52</p> <ul style="list-style-type: none"> -Those plates had been removed from the Cambro plate holder. -That plate holder had a large amount of tan, brown, and white specks along the sides and crumbs located in the bottom where the plates had been stored. -The above plate holder was located in the clean end of the dishroom. <p>Observation and interview on 2/25/15 at 12:08 p.m. with dietary assistant D in the dishroom revealed:</p> <ul style="list-style-type: none"> *She had been using a cloth from the bucket that contained a solution with suds to wipe down the counters. -This surveyor tested the above bucket with a quat test strip, and it tested zero ppm. -That test strip needed to have measured at least 150 ppm for proper sanitizing strength. *Dietary assistant D stated she used the cloths in the bucket to wipe down the counters and carts. *She stated the bucket's liquid had not been changed since she had come to work that day. -She stated she had started work at 9:00 a.m. -She was uncertain on the last time the bucket's liquid had been changed. *She then dumped out the liquid in the bucket and took the bucket to the three-compartment sink and: -She filled the bucket approximately two-third full with EcoLab Pantastic, a detergent. -That above detergent was not a sanitizer. -She then filled the bucket approximately one-third full with EcoLab Oasis 146 Multi-Quat Sanitizer. -She stated that this was how she filled the bucket used to sanitize the counters and carts. *This surveyor tested the above bucket with a quat test strip, and it tested zero ppm. 	F 371		

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F 371	<p>Continued From page 53</p> <p>-That test strip needed to have measured at least 150 ppm for proper sanitizing strength.</p> <p>Interview on 2/25/15 at 12:20 p.m. with the CDM regarding the above revealed the: *Sanitizer was not to have been mixed with the detergent. *CDM confirmed those areas were not being properly sanitized with a mixture of the EcoLab Pantastic detergent and the EcoLab Oasis 146 Multi-Quat Sanitizer. *CDM stated the above procedure needed to have been changed for proper sanitizing of the counters and carts.</p> <p>Interview on 2/25/15 at 12:25 p.m. with cook D regarding the level of the sanitizing liquid in the buckets revealed she stated it needed to have been at 200 ppm.</p> <p>Review of the provider's undated Product Specification Document of the Oasis 146 Multi-Quat Sanitizer product information revealed it: *Could be used to sanitize hard, non-porous, food contact surfaces such as tables, counters, and food processing equipment. *Was an effective sanitizer on food contact surfaces when used at 150 to 400 ppm active quat. *Was to have been exposed to surfaces as a sanitizing solution for a period of not less than one minute.</p> <p>2. Observation on 2/25/15 at 11:00 a.m. in the Town Square dining room revealed: *A Magic Chef microwave with a significant amount of yellow, brown, and orange splatters on the inside on the top, bottom, and the sides.</p>	F 371			

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F 371	<p>Continued From page 54</p> <p>*An Americana stove top with all four stove burner pans with a moderate amount of black and brown spots and a greasy-type film on them.</p> <p>Interview on 2/25/15 at 5:50 p.m. with the CDM regarding the microwave and the stove in the Town Square dining room revealed: *The activity department was responsible for cleaning the stove. -That department had a weekly bake and taste activity with the residents and was to have cleaned the stove after each use. *The dietary department was responsible for cleaning the microwave as of approximately one month ago. -That microwave was to have been cleaned by the activity or the dietary department prior to that. -That microwave was to have been cleaned by either department or "whoever had time."</p> <p>Observation on 2/26/15 at 8:30 a.m. in the Town Square dining room revealed: *The same microwave as previously observed on 2/25/15 at 11:00 a.m. with a significant amount of yellow, brown, and orange splatters on the inside on the top, bottom, and the sides. *The same stove top as previously observed on 2/25/15 at 11:00 a.m. with all four stove burner pans with a moderate amount of black and brown spots and a greasy-type film on them.</p> <p>Interview on 2/26/15 at 8:40 a.m. with the activity director regarding the above microwave and stove top revealed: *The activity department did a bake and taste activity with the residents each Thursday. *The activity department was responsible for cleaning the stove top. -There was not a cleaning schedule for that</p>	F 371		

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F 371	<p>Continued From page 55 stove.</p> <p>*The certified nursing assistants were responsible for cleaning the microwave when it had been used for heating resident food.</p> <p>-There was not a cleaning schedule for that microwave.</p> <p>3. Interview on 2/26/15 at 2:10 p.m. with the CDM in the kitchen revealed she agreed:</p> <p>*The vents in the kitchen needed to have been cleaned on a more frequent basis.</p> <p>-Six of those vents were directly over food preparation areas.</p> <p>*The fan in the walk-in cooler had not been cleaned for at least a couple of months.</p> <p>-It blew directly over the foods stored there.</p> <p>-It was not on a cleaning schedule, and it had needed to be cleaned more frequently.</p> <p>*The drawers contained pots, pans, and water pitchers used for preparing residents' food and drink.</p> <p>*The shelves contained utensils used for preparing and serving residents' food.</p> <p>*Four shelves in the dry food storage room were used for storage of residents' food and supplies.</p> <p>*Those above drawers and shelves needed to have been cleanable surfaces.</p> <p>*The shelf in the dishroom that contained chemicals needed to have been a cleanable surface and needed to have been replaced.</p> <p>*The plate holder in the dishroom needed to be cleaned more frequently.</p> <p>*The cooler threshold was not cleanable and needed to be replaced.</p> <p>*The hole in the floor next to the cooler threshold needed to have been repaired.</p> <p>Review of the kitchen daily and weekly cleaning schedules revealed:</p>	F 371			

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F 371	<p>Continued From page 56</p> <ul style="list-style-type: none"> *The dry food storeroom was to have been cleaned weekly on Friday by the a.m. aide. *The drawers and cabinets were to have been cleaned weekly on Sunday by the a.m. aide. *The floor was to have been swept and mopped daily by the p.m. cook. *None of the other areas were on the cleaning schedule including the: <ul style="list-style-type: none"> -The shelf in the dishroom. -The plate holder in the dishroom. -The cooler threshold. <p>Review of the provider's undated Quat Sanitizer policy revealed:</p> <ul style="list-style-type: none"> *All food contact surfaces were to have been sanitized. *"All staff in the dietary department use a quat sanitizer, which can be distributed from a dispenser near the 3 compartment sink. *Fill pail with sanitizer for sanitizing all counter tops and carts in kitchen. *Change solution every 2 hours or when it becomes cold and soiled. *Test the solution with the appropriate strip, it should test out at 200 parts per million." <p>Review of the provider's December 2008 Sanitization policy revealed:</p> <ul style="list-style-type: none"> *All food service areas were to have been maintained in a clean and sanitary manner. *Between use cloths used to wipe kitchen surfaces were to have been soaked in containers filled with approved sanitizing solution. <p>Review of the provider's undated General Sanitation of the Kitchen policy revealed the dietary staff would have maintained the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule.</p>	F 371		

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NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030	
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F 371	Continued From page 57	F 371		
F 431 SS=E	<p>Review of the provider's undated Cleaning Floors, Tables, and Chairs policy revealed the kitchen floors were to have been cleaned and sanitary.</p> <p>Review of the provider's undated Food Storage policy revealed food was to have been stored and prepared by methods designed to prevent contamination.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and</p>	F 431	<p>F431 Storage and Labeling of drugs</p> <ol style="list-style-type: none"> 1. Residents 15, 16, 17, 18, 22, 23, 3, 4, 11, 19, 20, 21, 24, 25, & 26 are unable to be completed for past non-compliance. 2. All residents are potentially at risk 3. a. The facility pharmacy provider was notified of a recent diversion investigation, although the consultant pharmacist was not informed of that event. The facility DON will notify the consultant pharmacist directly going forward of any diversion activity being investigated at the facility. b. All nurses and medication aides will be educated by the DON or designee on or before April 17th, 2015 on storage and labeling of medications. 	

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F 431	<p>Continued From page 58</p> <p>Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to: *Ensure policies and procedures were created and/or revised after drug diversion to: -Notify the consulting pharmacist when drug diversion had occurred to allow appropriate reconciliation between the pharmacy and the facility staff. -Re-educate authorized staff on reconciliation, handling, storage, and destruction of controlled narcotic medications and non-controlled medications in a timely manner for six of twenty-six sampled residents (15, 16, 17, 18, 22, and 23). *Ensure open dates and used by dates (when applicable) were written on the medication container that required dating after opening for fifteen of twenty-six sampled residents (3, 4, 11, 19, 20, 21, 24, 25, and 26). Findings include:</p> <p>1. Interview on on 2/24/15 at 11:15 a.m. with the director of nursing (DON) and the director of clinical services regarding the recent drug diversion the week prior to the survey revealed: *The DON stated she had reconciled all the medications in the facility. *They had a policy they were implementing where</p>	F 431	<p>c. The DON or designee will complete written audits weekly x 4, then monthly x 3 on drug storage and labeling</p> <p>4. Results of the written audits will be taken to the facility QAPI committee monthly by the DON or designee for review and recommendations.</p>	
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F 431	<p>Continued From page 59</p> <p>she would check the electronic medication administration record (eMAR) against the narcotic administration record each Friday.</p> <p>*She held a meeting with staff and educated them on diversion and appropriate reconciliation.</p> <p>*She stated she had a mandatory sign-in sheet to ensure all staff were present.</p> <p>*She would get that sheet and the list of topics covered.</p> <p>*The director of clinical services consultant stated the consultant pharmacist had been notified and had been present for the reconciliation of medications.</p> <p>Review on 2/25/15 between 10:00 a.m. and 2:00 p.m. of the 100 wing, 200 wing, and 300 rehabilitation (rehab) wing medication carts and their medications revealed:</p> <p>*Resident 15's Trazodone (an antidepressant) medication dose number 19 and dose number 20 had been punched out of the blister pack. A medication had been put back in the blister pack spot and tape applied behind it.</p> <p>*Resident 16's Trazodone medication dose number 10 had been punched out of the blister pack. A medication had been put back in the blister pack spot and tape applied behind it.</p> <p>*Resident 3's Atropine (dries up secretions) drops were not labeled with an opened date.</p> <p>*Two stock medication glycerin suppositories (helps start a bowel movement) packages were found opened without the medication in them.</p> <p>*Resident 17's chlorhexidine (an antibacterial rinse) had been opened and not dated.</p> <p>*Resident 11's Tramadol (narcotic pain medication), dose number 1 had been punched out of the blister pack. A medication had been put back in the blister pack spot and tape applied</p>	F 431		

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F 431	<p>Continued From page 60 behind it.</p> <ul style="list-style-type: none"> *Resident 18's Tramadol had twelve pills remaining of thirty unit doses but only thirteen had been signed off in the narcotic book as given. *Resident 11's Advair (an inhaled medication) had no used by date written on it. *Resident 19's Advair had no used by date written on it. *Resident 20's Lactulose (for constipation) was not dated when it had been opened. *Resident 21 had neomycin (antibiotic ointment) that had been undated when opened. *Resident 4 had two opened bottles of Ketotifen fumarate (for itching of the eye) that were not written on when they had been opened. *Resident 22's Azythromax (an oral antibiotic) and resident 23 and 11's Nitroglycerin (heart medication) oral tablets had been co-mingled with suppositories and other various topical medications. *Resident 24's Lactulose had no date when opened. *Resident 25's Advair had no opened or used by date written on it. *Resident 26's Ventolin (inhaled medication) had no opened date written on the packaging. <p>Interviews on 2/25/15 between 10:00 a.m. and 11:00 a.m. with certified nursing assistant (CNA) M and registered nurse (RN) F regarding the above medications revealed:</p> <ul style="list-style-type: none"> *They agreed they should have dated medication when it had been opened and used if applicable. *Both were unaware of the blister packs of the above medications that had been opened and re-taped. *RN F had not signed off on the narcotic sheet when she gave the medication to resident 18. 	F 431			

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F 431	<p>Continued From page 61</p> <p>Interview on 2/25/15 at 2:15 p.m. with the DON regarding the above medications revealed: *It had been her expectation that staff: -Would not re-tape medications into a blister pack once removed. -Would write opened and used dates on appropriate medications. -Co-mingle medications of different routes (oral, topical, and rectal). -She had identified the medications found in the opened blister packs. -She would destroy those medications in the presence of another nurse.</p> <p>Interview on 2/26/15 at 1:15 p.m. the DON notified this surveyor she had no sign in sheet for the mandatory meeting and had not specifically spoken with staff about drug diversion.</p> <p>Interview on 2/26/15 at 1:48 p.m. with consultant pharmacist N regarding the above mentioned diversion and medications revealed: *He was not informed of the drug diversion that had happened the previous week and had not been present for the mandatory meeting or drug reconciliation. *He had been in the facility on 2/24/15, and no had staff advised him of the above at that time. *His consultant manager had not reported any diversion to him either. *He had been unaware medications including narcotics had been taped back into the blister packs. *He agreed that would not be an acceptable practice. *They (consulting pharmacy) had a cart auditor for the medications carts that reconciled those medications specifically. He would alert her to the diversion and have her audit the facility cart</p>	F 431		

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F 431	<p>Continued From page 62 medications as soon as possible.</p> <p>Interview on 2/26/15 at 2:25 p.m. with the DON and consultant director of clinical services revealed: *He had assumed the consulting pharmacist had been at the facility following the drug diversion. *The DON stated she had called the consultant pharmacy manager not the consulting pharmacist but had no documentation of the call.</p> <p>Review of the provider's July 2013 Medication destruction policy revealed: *Non-controlled medications must be destroyed in the presence of two licensed nurses. *The drug disposition record must contain all information about the medication and also its reason for destruction and witness signatures.</p> <p>Review of the provider's March 2013 Narcotics-Counting Of policy revealed: *Each time a substance had been given it would be entered into the narcotic book and the quantity left identified. *Controlled substance count verification should be done every shift by two nurses. *Controlled substances may only be destroyed with the DON and pharmacist present.</p> <p>Review of the January 2011 Medication Guide instructions for use that came with the Advair revealed "Take Advair Discus out of the box and foil pouch. Write the pouch opened and 'use by' dates on the label. The use by date is one month from opening the pouch.</p> <p>A policy on pharmacy services responsibilities (or contract) and drug diversion were requested at the time of this survey of the consulting director of</p>	F 431			

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F 431	Continued From page 63 clinical services. He reported they had no written diversion policy.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	F441 Infection Control 1. Residents #3, 6 & 13 are unable to be corrected for past non-compliance. 2. All residents are potentially at risk. 3. All nurses will be educated by the DON or designee on infection control practices with a dressing change. All Nurses and Medication Aides will be educated on the glucometer cleaning policy by the DON or designee. Education will be completed on or before April 17 th , 2015. DON or designee will complete written audits weekly x 4, then monthly x 3 on dressing changes and glucometer cleaning. 4. Results of the written audits will be taken to the facility QAPI committee monthly by the DON or designee for review and recommendations.	4.17.15

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F 441	Continued From page 64 infection. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 A. Based on observation, interview, and policy review, the provider failed to ensure appropriate infection control technique was maintained for one of one dressing change (resident 3), and one of one glucometer (machine used to check blood sugar) reading performed on two of two residents (6 and 13). Findings include: 1. Observations on 2/25/15 at 7:40 a.m. and again at 7:43 a.m. of registered nurse (RN) F after she had checked blood sugar tests on residents 6 and 13 revealed: *She had checked resident 6's blood sugar. *She set the glucometer on the medication cart before she cleaned it. *She removed her dirty gloves. *She sanitized her hands and put on a pair of clean gloves. *With her clean gloves she picked up the glucometer and wiped it with a Sani-wipe (a disinfectant that must stay wet for two minutes to kill bacteria). *She put it in her medication cart without keeping it wet for the two minute contact time. *With her then dirty gloves she proceeded to type on her computer keyboard to access the electronic medication administration record (eMAR). *She reopened the drawer with her gloved hands, pulled out the glucometer, and set it on the medication cart.	F 441		

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F 441	<p>Continued From page 65</p> <ul style="list-style-type: none"> *She proceeded to open another drawer and get an alcohol wipe and a test strip for the glucometer. *She then opened the alcohol wipe, threw away the package, and set it on the top of the glucometer. *As she walked to resident 13's room she dropped her pen on the floor. *She picked up her pen from the floor with her gloved hand. *She then proceeded to check resident 13's blood sugar. *She returned to her cart and pulled her keys from her pocket. *She set the glucometer on the top of the medication cart and removed her soiled gloves. *She wiped the glucometer with the Sani-wipes and returned it to the top drawer of the cart. <p>2. Observation on 2/25/15 at 9:50 a.m. with RN F as she performed a dressing change on resident 3 revealed she:</p> <ul style="list-style-type: none"> *Placed the clean dressing packages on the pillow next to her feet without providing a clean barrier. *Removed the dressing on her left outer ankle and heel. *Set them on the pillow case by the resident's feet. *Applied the new dressings without cleansing the wounds. *Picked up the dirty dressings, threw them away, and removed her gloves. *Had left the pillow on the resident's bed and exited the room. *She used hand sanitizer once out of the room and put on new gloves. <p>Interview on 2/25/15 with RN F immediately</p>	F 441		

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F 441	<p>Continued From page 66</p> <p>following the above dressing change regarding her infection control technique revealed she agreed:</p> <ul style="list-style-type: none"> *It was not appropriate to open an alcohol wipe and set it on the glucometer. *The alcohol wipe should not have touched anything but the resident's skin. *She should not have placed soiled dressings on the resident's pillow. *She should have washed the resident's wound prior to applying a clean dressing. *Agreed she should have followed appropriate infection control technique with the above tasks. <p>Review of the providers's July 2013 Glove Use policy revealed gloves:</p> <ul style="list-style-type: none"> *Should be used to prevent contamination when providing treatments, care, and when cleaning contaminated surfaces. *Gloves should have been changed when they became contaminated. <p>Review of the provider's April 2014 Dressings Clean/Aseptic policy revealed supplies should have included:</p> <ul style="list-style-type: none"> *A plastic bag for discarded dressings that was necessary to perform the procedure. *A cleaning solution as ordered. *A barrier to establish a clean field. <p>Review of the provider's May 2014 Blood Glucose Monitor Disinfection policy revealed steps to disinfect a glucometer were:</p> <ul style="list-style-type: none"> *Gather equipment. *Place it in a beside table. *Hands were to be washed and gloves applied. *After performing the test clean all external parts of the monitor with the disinfectant wipe. *Continue wiping to keep wet and ensure a 	F 441			

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F 441	Continued From page 67 contact time of two minutes. *Gloves were to be removed and handwashing completed. *The monitor would then be placed in the medication cart. Surveyor: 16385 B. Based on record review and interviews, the provider failed to ensure the organism identified by laboratory (lab) culture was recorded on the monthly antibiotic review log. Findings include: 1. Record review of the antibiotic log revealed the provider had not included the organism identified from lab culture on monthly review logs for 2014 and 2015. Interview on 2/26/15 from 10:00 a.m. to 10:45 a.m. with the director of nursing, assistant director of nursing, and nurse consultant confirmed the organisms had not been included on the monthly antibiotic review log. The organisms had been included in the residents' medical records on the lab reports but not transferred to the antibiotic review log.	F 441			
F 467 SS=D	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, testing, interview, record	F 467			

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NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 467	<p>Continued From page 68</p> <p>review, and instructions review, the provider failed to maintain exhaust fan ventilation in one of one storage room (janitor's kitchen closet). Findings include:</p> <p>1. Observation on 2/24/15 from 8:15 a.m. through 8:58 a.m. of the janitor's kitchen closet revealed: *The door had been closed. *There were a janitor's floor sink, chemicals, and a wastebasket in the room. *A strong odor was present in that room. *There was a vent in the ceiling. *Testing of the vent with a paper towel revealed: -It did not show any air flow present when covered. -There was not adequate outside ventilation in the storage room.</p> <p>Interview during the above observation with the certified dietary manager (CDM) regarding the janitor's kitchen closet revealed she: *Agreed there was a strong odor present in the storage room. *Had not been aware the ventilation was not functioning properly in that room. *Stated maintenance had been responsible for maintaining the ventilation.</p> <p>Observation and interview on 2/26/15 at 2:10 p.m. with the CDM in the janitor's kitchen closet revealed: *The door had been propped open with a wastebasket. *Testing of the above vent again with a paper towel revealed: -It had not shown any air flow present. -There was not adequate outside ventilation in that room. *She confirmed there needed to have been</p>	F 467	<p>F467 Outside Ventilation</p> <p>1. No specific residents were cited in the 2567</p> <p>2. All residents are potentially at risk</p> <p>3. The Janitor's Kitchen Closet vent will be replaced with a new automatic exhaust fan. An estimate will be received by April 17th, 2015 for the job and completion of that job will be by April 17th, 2015 or as soon as possible.</p> <p>The Administrator will oversee obtaining the estimate for the exhaust fan and completion of the work.</p> <p>4. The administrator or designee will report any issues w/ the exhaust fan project to the facility QAPI committee monthly and ongoing.</p>	4/17/15	

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NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030	
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F 467	Continued From page 69 adequate outside ventilation in that room. Record review of the provider's 2/28/14 through 1/31/15 Work History Report for preventive maintenance revealed: *Exhaust fans were to have been inspected monthly for proper operation. *There had been no monthly inspection in November 2014. *All exhaust fans had last been inspected on 1/26/15. Review of the provider's undated Instructions for the exhaust fans for proper operation revealed: *All exhaust fans including the kitchen janitor's closet storage room were to have been checked. *To have ensured that air flow was sufficient enough to hold a piece of paper to the vent when operating.	F 467		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	F514 Accurate Medical Record 1. Residents 3 & 11 cited in the deficiency are unable to be corrected for past non-compliance. 2. All residents are potentially at risk 3. Refer to tags F250, F279 & F281 for the Plan of Correction details, including education and audits. 4. Refer to tags F250, F279, & F281 for QAPI information.	4-17-15

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NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	Continued From page 70 by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to ensure accurate documentation in the medical record for two of eleven sampled residents (3 and 11). 1. Review of the provider's July 2013 Nursing ADL (activities of daily living) Documentation policy revealed: **"To provide concise, accurate, and timely documentation." **"To provide accurate and timely support for information provided in the resident's plan of care." Refer to F250, finding 1; F279 findings 1 and 2; and F281, findings 1 through 4.	F 514			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10623	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030
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(X4) ID-PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	<p>Initial Comments</p> <p>Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/24/15 through 2/26/15. Palisade Healthcare Community was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Paul Wells

TITLE

Adm

STATE FORM

6899

PWDU11

<p>RECEIVED</p> <p>MAR 20 2015</p> <p>SD DOH L&C</p>	(X6) DATE
	If continuation sheet 1 of 1

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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: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2015
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NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/25/15. Palisade Healthcare Community was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ram Wilson</i>	TITLE <i>Adm</i>	(X6) DATE <i>3-17-15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting, providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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MAR 20 2015

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