

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

ORIGINAL

PRINTED: 07/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER WESTHILLS VILLAGE HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 255 TEXAS ST RAPID CITY, SD 57701	
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F 000	INITIAL COMMENTS Surveyor: 32355 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/19/15 through 5/21/15. Westhills Village Health Care Facility was found not in compliance with the following requirements: F280, F309, F314, and F431.	F 000	The creation and submission of this plan of correction does not constitute admission by this provider of any conclusions set forth in the statement of deficiencies or any violation of regulation.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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. This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, care plan	F 280	HEALTH CARE POC Westhills Village Health Care operates in a capacity ensuring quality of care and services to our residents. Facility adheres to the State and Federal guidelines by staying within regulatory compliance under the direction in which we are licensed. Items listed in this report have a coinciding correction listed in the right hand column. <u>F280</u> <u>The facility does review, revise and individualize care plans for residents.</u>	<i>6/30/15</i>

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

[Signature]

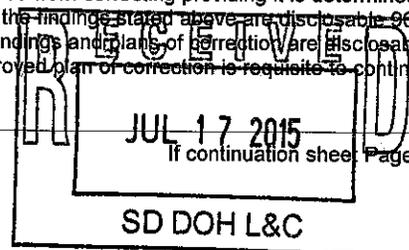
Administrator

TITLE

(X6) DATE

7/15/15

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 required to continue program participation.



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F 280	<p>Continued From page 1</p> <p>review, and policy review, the provider failed to review, revise, and individualize care plans for 4 of 11 sampled residents (6, 7, 9, and 11). Findings include:</p> <p>1. Review of resident 6's medical record revealed: *A re-admission date of 1/26/15. *Diagnoses of dementia (forgetfulness), history of falls, osteoporosis (weak bones), anorexia (eating disorder with weight loss), and debility (weakness). *He had required extensive assistance of one staff member for transfers and moving in bed. *He had been at risk for skin breakdown with a current facility acquired open area (pressure ulcer) to his buttocks and a history of other open areas.</p> <p>Review of resident 6's current care plan revealed: *A focus area: "I have potential for pressure ulcers related to limited mobility, incontinence [lack of bladder control], fragile skin" with a start date of 2/26/15. -An intervention for that focus area: "I have a pressure-reducing mattress and a cushion in my wheelchair." *A focus area: "I have a pressure ulcer to my right lower buttock noted on 4/24/15. It is unstageable [type of pressure ulcer that is covered in slough and the depth is unable to be determined]" with a start date of 5/1/15. -An intervention for that focus area: "Please turn and reposition me as appropriate." --No intervention on how often he should have been repositioned. -Another intervention for that focus area: "I have a pressure-relieving device air overlay, roho cushion."</p>	F 280	<p>Facility practice for repositioning residents as appropriate is based on staff providing resident centered care, consistent staffing assignments and their detailed knowledge of resident preferences as well as fluctuation in resident's physical and/or psychological condition</p> <p>Resident #6 care plan was developed by the interdisciplinary team, resident and resident's family</p> <p>Interventions in place for Resident #6 include: pressure reducing mattress, air overlay, ROHO cushion on wheelchair, dietary supplements (Med Pass, Juven) Tena moisture barrier cream, appropriate Tena absorbing products, calmoseptine barrier cream. Resident is able to independently change and control his body position both in bed and in wheelchair.</p>	

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F 280	Continued From page 2 Observation on 5/19/15 from 8:25 a.m. through 3:25 p.m. of resident 6 revealed: *He had been sitting in a wheelchair. *He had been to breakfast, activities, lunch, and wheeling himself throughout the facility during the above timeframe. Interview on 5/19/15 at 3:20 p.m. with certified nursing assistant (CNA) J revealed she had taken resident 6 to the bathroom around 10:00 a.m. He had been in his wheelchair since that time. She further stated that would be normal routine for his day. Observation and interview with CNA K on 5/19/15 at 3:25 p.m. of resident 6's transfer and personal care revealed: *She had used the sit-to-stand lift (a type of mechanical lift used to move a resident from one place to another) to transfer him to the toilet and back to his wheelchair. *He had been incontinent of urine, through his brief and his pants. -The cushion in his wheel chair had a wet spot where he had been sitting. *She performed incontinence care. *She usually worked in the evenings. *The evening staff normally toileted him before and after supper. *He liked to roam the hallways in his wheelchair. *Sometimes they assisted him to bed right away after supper, and sometimes he stayed up in his wheelchair as late as 9:00 p.m. *He had a dressing in place to the right lower buttocks. *She was aware of the pressure ulcer on his buttocks. -She was unsure how long it had been there.	F 280	Resident' #6 preference is to be in wheelchair for extended periods of time and has history of refusing staff when directed, when offered and when given options to lie down in bed. Family/Responsible Party is fully aware of resident refusing to lie down and acknowledges resident's preference and choice is to remain up and in wheelchair.	

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F 280	<p>Continued From page 3</p> <p>Random observations of resident 6 and his room from 5/19/15 at 8:25 a.m. through 5/21/15 at 8:05 a.m. revealed the following: *He used a wheelchair for getting around. -He was able to propel the wheelchair on his own. -He had a ROHO (specialty) cushion in his wheelchair. *He had a pressure relieving mattress on his bed. -No air overlay was noted on his bed, as indicated on the care plan. *Staff had assisted him with transfers using the sit-to-stand lift. *He was incontinent of urine. *Staff assisted him with personal care including incontinence care.</p> <p>Observation and interview on 5/20/15 at 7:45 a.m. with LPN A and the MDS nurse during a dressing change to his right lower buttock revealed: *He had an unstageable pressure ulcer to the right lower buttock. *There was a scar to his left lower buttocks from a previous pressure ulcer.</p> <p>Interview on 5/20/15 at 8:25 a.m. with CNA B revealed resident 6: *He normally would have gotten up for the day around this time. *He was active and liked to cruise around the facility in his wheelchair. *He sometimes refused to lay down in bed. *She stated he should have been repositioned at least every two hours.</p> <p>Interview on 5/20/15 at 4:25 p.m. with licensed practical nurse (LPN) G revealed the staff should have toileted resident 6 every two hours and</p>	F 280	<p>Air Overlay mattress was removed on 5/19/15 on night shift as mattress was dirty and needed to be cleaned. Air Overlay mattress was replaced on 5/21/15.</p>	

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F 280	<p>Continued From page 4 would normally have laid him down after supper. She stated sometimes he refused to lay down.</p> <p>Further review of resident 6's current care plan revealed: *There was no mention of: -How often he should have been repositioned. -If he had a history of refusing to reposition or lay down. *A focus area: "I require assistance with my ADL's related to weakness, recurrent UTI." -An intervention for that focus area: "For my transfer status, please refer to the transfer status posted." -It did not mention that he used the sit-to-stand lift.</p> <p>Surveyor: 32355 2. Review of resident 7's medical record revealed: *An admission date of 3/27/15. *Diagnoses of dementia (forgetfulness), Alzheimer's (memory loss), history of falls, diabetes mellitus (DM) (unstable blood sugar levels), and atrial fibrillation (irregular heart beat). *He had required extensive assistance of one staff member for transfers and moving in bed. *He had been at risk for skin breakdown with two facility acquired open areas to his bottom. *One of the open areas had been documented by the staff as healed on 5/19/15.</p> <p>Observations on 5/19/15 from 1:00 p.m. through 4:00 p.m. of resident 7 revealed: *He had been laying on his bed sleeping. *He had been laying on his back during that entire time frame.</p>	F 280	<p>Resident #7 care plan was developed by the interdisciplinary team, resident and resident's family</p> <p>Interventions in place for Resident #7 include: pressure reducing mattress, air overlay, protective heel booties, cushion on wheelchair, dietary supplements (Med Pass, Juven) , diabetic foot checks, , Tena moisture barrier cream, appropriate Tena absorbing products, Ucerin cream. Resident is able to independently change and control his body position both in bed and in wheelchair.</p>	

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F 280	<p>Continued From page 5</p> <p>Interview on 5/21/15 at 9:20 a.m. with licensed practical nurse (LPN) F revealed all residents should have been repositioned every two hours. She would have to ask the director of nursing (DON) if it was acceptable for resident 7 to lay in one position for greater than two hours.</p> <p>Review of resident 7's current care plan revealed: *A focus area: "I have potential for pressure ulcers related to DM, limited mobility [moving on my own], incontinence" with a start date of 3/27/15. *An intervention for that area: "Please turn and reposition me as appropriate." -No intervention or direction for staff on how often he should have been repositioned.</p> <p>Review of resident 7's interdisciplinary notes by LPN A revealed on: *5/1/15 at 3:40 p.m. "Stage 2 pressure ulcer [outer layer of skin is missing] noted to left of coccyx [tailbone]." *5/1/15 at 3:42 p.m. "Stage 2 pressure ulcer to coccyx now a stage 3 [full thickness tissue loss. Subcutaneous fat may be visible]."</p> <p>Review of resident 7's current care plan revealed: *A focus area: "I have a pressure ulcer to my coccyx noted on 4/27/15. It is a stage II with a start date of 5/1/15." *A goal under that area: "I would like to maintain or improve my pressure ulcer through my next review." *There had been no documentation on the care plan to support he had: -A new open area to the left side of his coccyx. -The stage 2 on his coccyx had worsened and now was a stage 3.</p>	F 280	<p>Resident #7 rested on 5/19/15 from 1:00pm to 4:00pm and is able to reposition himself independently in bed. Facility practice and resident preference is to limit sleep interruptions to ensure proper and sufficient sleep for all residents.</p>	

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F 280	<p>Continued From page 6 Surveyor: 35237 3. Interview on 5/20/15 at 10:15 a.m. with the director of nursing (DON) and the administrator revealed: *Staff used the care plans to care for the residents. *The Minimum Data Set (MDS) assessment nurse was in charge of the care plans. *The nurses had been educated, but they would not have added entries or edited the care plans. *Regarding resident 6's care plan and specifically the entry to "turn and reposition me as appropriate." -The DON had stated it was okay as written. -She further stated the CNAs knew what was expected related to turning and repositioning the residents. -She did not feel the care plan needed a specific plan or schedule for repositioning since the staff had been educated. *The DON was unsure if the mattress resident 6 had on his bed currently was the one that was on at the time of re-admission to the facility. -She was unsure when or if the air overlay was removed. -She stated they had an air overlay available for use currently in the store room.</p> <p>Surveyor: 32355 4. Review of resident 9's medical record revealed: *An admission date of 3/27/15. *Diagnoses of cerebral vascular accident (stroke) with left sided weakness and dysphagia (swallowing problems). *He had been admitted with a gastrostomy tube (G-tube) (tube inserted through the abdomen into the stomach for nutrition and medication administration).</p>	F 280	<p>Resident #9 admitted to facility with J-tube on 3/27/15, discharged to hospital on 4/24/15, and re-admitted to facility on 4/27/15.</p>		

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F 280	<p>Continued From page 7</p> <p>Review of resident 9's May 2015 medication administration record revealed: *He had been receiving nutrition through the G-tube from the time of his admission until 5/1/15. *The G-tube was to have been: -Checked for proper placement by the nursing staff once a shift. -Flushed with 30 milliliters of water every shift.</p> <p>Review of resident 9's 5/1/15 care plan revealed no documentation to support he had a G-tube.</p> <p>Interview on 5/20/15 at 3:00 p.m. with the DON confirmed the G-tube should have been documented on his care plan. Surveyor: 27473</p> <p>5. Review of resident 11's record revealed: *An admission date of 3/23/15. *Diagnoses or identified problems of hypothyroidism (low thyroid), hyperlipidemia (elevated cholesterol), mild cognitive (memory) disorder, hypertension (elevated blood pressure), heart disease with bradycardia (slow pulse), cerebrovascular disease (disorder that affects the blood vessels of the brain and face), gastroenteritis (inflammation of the intestines), osteoarthritis (disease of the joints), pyelonephritis (inflammation of the kidney and upper urinary tract), recurrent urinary tract infection, and had fallen several times prior to admission. *Family had inquired about hospice care prior to admission; she was considered comfort care. *Fall risk assessment dated 3/24/15 reflected a total score of thirteen. A total score of ten or greater indicated high risk for potential falls. *Her Brief Interview for Mental Status score was</p>	F 280	<p>The facility did care plan the J-tube for Resident #9. The J-tube was removed from care plan for Resident #9 on 5/6/15 as J-tube site was healed and Resident #9 was no longer receiving nutrition via the J-tube. Care of the J-tube site and auscultation (action of listening to sound) along with free water flushes to ensure patency (ensure tube is open) were and continue to be reflected on the eMAR. Facility practice is to not care plan healed incisions/sites.</p> <p>Resident #11 was assessed upon admission by interdisciplinary team. Care plan reflects that resident is a fall risk due to incontinence, weakness, impaired balance, oxygen tubing. Facility determined that a soft touch call light would be more appropriate based on resident's ability. A soft touch call light is easier for the resident to press and can</p>	
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F 280	<p>Continued From page 8</p> <p>four meaning she had severe cognitive (memory) impairment or did not fully understand instructions.</p> <p>Observation on 5/20/15 at approximately 10:30 a.m. around lunch time of resident 11 revealed she was seated in her room in a side chair. She was attempting to get herself out of the chair with no assistance from staff. Housekeeper H entered her room and attempted to encourage her to remain seated telling this surveyor, "She isn't to try to get up or walk by herself. She has fallen before." Resident 11 did not appear to understand what the housekeeper was telling her. Housekeeper H put on the call light, and then asked this surveyor to stay while she sought assistance. Several unidentified staff arrived momentarily as the housekeeper returned. Resident 11 in a joking manner appeared to accept what the assembled group was encouraging. There was a bruised area with swelling still present to right temporal region above the level of the eyebrow. A closed scratch ran through the area. The group of staff stated she fell in her room last night.</p> <p>Review of resident 11's 3/23/15 care plan for falls revealed the following approaches: ""*Please complete a fall risk assessment on me quarterly. *Please schedule therapy services for me as appropriate. *Please keep my suite [room] clutter free and well-lit during waking hours. *Please ensure my call light is within reach and encourage me to use it."</p> <p>Review of resident 11's 5/19/15 care plan for falls revealed the following approaches:</p>	F 280	<p>be strategically positioned to alert staff if the resident changes position (example in bed or wheelchair). Many discussions were held between the facility and the family/responsible party regarding the resident's pattern and past history of getting up without assistance. Facility and family have been and will continue to work together on appropriate interventions for this resident.</p> <p>Care plan reflects to schedule therapy as appropriate which began on 3/24/15 to 4/7/15; keep room clutter free; ensure call light is within reach and encourage to use.</p> <p>Staff continues to educate Resident #11's on the use of her call light in the anticipation that she would recall that information and use it. This is shown in her BIMS score fluctuations.</p> <p>Facility continues to educate staff on</p>		

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F 280	<p>Continued From page 9</p> <p>"*Please complete a fall risk assessment on me quarterly.</p> <p>*Please encourage me to participate in activities.</p> <p>*I may need assistance to wear non-skid footwear.</p> <p>*Please remind me to lock my wheelchair brakes and call for help when I need to transfer.</p> <p>*Please keep my suite clutter-free and well-lit during waking hours.</p> <p>*Please keep my call light within reach and where it will alert staff to my getting up on my own and encourage me to use it.</p> <p>*Please do not leave me unsupervised during toileting.</p> <p>*Assist me to the bathroom routinely throughout the day. Anticipate my needs."</p> <p>Care plan review and interview on 5/21/15 at 7:45 a.m. LPN F revealed she would not anticipate resident 11 to use her call light and ask for assistance, or remember to lock her wheelchair brakes. She stated it was, "The policy to re-educate on the off chance she might remember."</p> <p>Care plan review and interview on 5/21/15 at 9:00 a.m. with LPN I revealed she agreed she would not anticipate resident 11 to activate her call light or lock her wheelchair brakes. It was more realistic to "keep an eye on her when going up and down the hall or getting her out to more activities."</p> <p>Interview on 5/21/15 at 9:10 a.m. with certified nurse assistant/medication aide C revealed she agreed resident 11 had "no concept of how, or when, and why to use her call light."</p> <p>Review of the fall prevention procedure revealed:</p>	F 280	<p>prevention for those residents who are at fall risk with our monthly Fall Safety Risk Committee Meeting.</p> <p>Care Plan/RAI Process policy was given to surveyors at the time of the survey.</p> <p>Education of all nursing staff on the Care Plan/RAI policy will be completed by DON or designee at the nursing staff meeting scheduled for 6/17/2015.</p> <p>The Administrator or designee will in-service the Interdisciplinary Team regarding the Care Plan/RAI Process policy by 6/17/2015</p> <p>DON/Clinical Coordinators reviewed and updated care plans for residents 6, 7, 9, and 11 by 6/12/2015.</p> <p>DON/Clinical Coordinator or designee will review all care plans for proper interventions. Care Plans will be updated and individualized after</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER WESTHILLS VILLAGE HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 255 TEXAS ST RAPID CITY, SD 57701	
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F 280	Continued From page 10 "Resident care plans will reflect they are a fall risk. Interventions will be documented in the Resident's care plan. A fall assessment will be completed on all Residents at admission, if there is a significant change, and annually. Residents determined to be at high risk for falls will have appropriate preventative measures implemented as determined by the interdisciplinary team and documented in the care plan...."	F 280	scheduled care conferences either quarterly or when there is a significant change.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure effective chronic pain management for one of six sampled residents (4) who exhibited signs and symptoms of increased pain during transfers. Findings include: 1. Review of resident 4's complete medical record revealed: *An admission date of 2/12/13. *Diagnoses of depression (sadness), dementia (forgetfulness), history of pain in the joints and lower legs, and hard of hearing.	F 309	Administrator/DON or designee will audit care conference ID notes for those that have triggered weekly to ensure care plans were reviewed, revised, individualized, and that resident/responsible party had opportunity to participate. Findings will be reported quarterly to QA Committee by Administrator/DON or designee for further direction or steps. <u>F309</u> <u>The facility does provide and all residents do receive effective pain management to ensure their highest level of well-being.</u> Facility puts a high priority on ensuring residents pain is well controlled. Staff provide resident centered care, as well as consistent staffing assignments.	7/10/15

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F 309	<p>Continued From page 11</p> <p>*The staff had to anticipate her needs due to her communication problems. She had a history of slurring and stuttering her words when talking with others.</p> <p>*She had been dependent on staff to meet all of her activities of daily living needs.</p> <p>*She had taken Tylenol (pain reliever) 1,000 milligrams (mg) twice a day for pain. She had been taking the scheduled Tylenol since 6/29/13.</p> <p>*She had an order for:</p> <ul style="list-style-type: none"> -Tylenol 500 mg two tablets twice (BID) a day as needed (PRN) for pain since 6/8/13. -Tramadol (pain reliever) 50 mg one tablet every 8 hours PRN for pain since 5/7/14. <p>Review of resident 4's 2/20/15 Minimum Data Set (MDS) annual assessment revealed:</p> <p>*She was hard of hearing and usually understood the staff.</p> <p>*Her memory recall was severely impaired. Her Brief Interview for Mental Status (memory test) score was two indicating she had severe cognitive impairment or did not fully understand others.</p> <p>*She required extensive assistance of one staff member for transfers and moving in bed.</p> <p>*She had ambulated only in her room.</p> <p>*Her pain interview revealed she occasionally had pain and rated it a 3 on a scale of 1 to 10 with 10 being the worst pain.</p> <p>*She had received scheduled pain medications during the assessment time frame with no PRN pain medication given.</p> <p>*No non-medication interventions had been provided.</p> <p>Review of resident 4's March 2015 annual assessment by the MDS coordinator revealed:</p> <p>**She has significant arthritis [inflammation and</p>	F 309	<p>Staff have detailed knowledge of resident preferences as well as fluctuation in resident's physical and/or psychological well being.</p> <p>Resident #4 has a diagnosis of dementia as well as diagnosis of dementia with behavioral disturbances and history of refusing medications including scheduled pain medications. When Resident 4 refuses scheduled medications, facility utilizes PRN (as needed) medications to ensure adequate pain control.</p> <p>Pharmacy consults note that resident has paranoia and behavioral disturbances related to diagnosis of dementia with behavioral disturbances.</p> <p>Facility consults with physician regarding Resident 4's behavior or discomfort and physician makes determinations on how to effectively manage behavior or discomfort.</p>	

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F 309	<p>Continued From page 12</p> <p>pain in the joints] especially in knees which affects her ability to ambulate." ***"When asked about pain, she denies pain." ***"She is taking Tylenol 1000 mg BID. She did not require PRN pain meds [medications] this ref [reference] period." ***"[Resident name] does vocalize pain to others and it is usually only with movement d/t [due to] arthritis."</p> <p>Review of resident 4's interdisciplinary notes revealed: *On 2/20/15 licensed practical nurse (LPN) G documented: -"Denies pain." -"Knees grind and crackle with movement." -"Will spit out pain pill."</p> <p>Interview on 5/20/15 at 2:00 p.m. with certified nursing assistant (CNA) B regarding resident 4 revealed: *She had required assistance from staff with transfers. *She could have been transferred with one person using a gait belt, stand, and pivot (turn) or a sit-to-stand transfer aide (device used to assist residents with transfers). *The type of transfer the staff had used to assist the resident depended upon the type of day she was having. Her knees were very arthritic and caused her a lot of pain. *The staff had been using the transfer lift more often due to the increased pain in her knees. That had decreased the pain and discomfort with transfers.</p> <p>Observation on 5/20/15 at 3:30 p.m. with CNA D assisting resident 4 with toileting revealed: *He had:</p>	F 309	<p>Family of Resident 4 is involved in care, is aware of vocalizations, states vocalizations of "No, no, no" are related to anxiety not pain, and that Resident #4 has history of vocalization typically with transfers to toilet that pre-dates admission to facility. Family of Resident #4 is involved and aware regarding resident's behavior and anxiety related to calling out. Family has stated and expressed numerous times that these vocalizations are related to anxiety and behavior.</p> <p>CNA D did ask Resident 4 about pain during the transfer and notified charge nurse. Behavior or discomfort issues were resolved upon completion of transfers and toileting as per resident history.</p>		

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F 309	<p>Continued From page 13</p> <ul style="list-style-type: none"> -Brought the resident inside the bathroom. She had been sitting in her wheelchair (w/c). -Instructed her to use the hand rail by the toilet to assist her with standing and sitting on the toilet. *She had become very anxious prior to and during the entire process of transferring from her w/c to the toilet. -During that time she had grimaced (facial expression), groaned, cried out and voiced several times "I can't, I can't, I don't know." *She had stuttered and slurred her speech more as her anxiety level increased. *She had become quieter and calmer after the transfer was complete and she was not moving. *After the resident had voided she had: <ul style="list-style-type: none"> -Been required to transfer from the toilet back to the w/c. -Became increasingly anxious and repeated the same words as observed above. *After the transfer had been complete she was calmer, quieter, and easier to understand. *CNA D had not been observed asking the resident if she had pain or discomfort during either transfer. <p>Interview on 5/20/15 with CNA D at the time of the above observation regarding resident 4 revealed:</p> <ul style="list-style-type: none"> *Her knees were arthritic, cracked, and popped with transfers and movement. *She had a lot of pain in her knees with movement and transfers. *She always had those behaviors during transfers and movement. *All of the nursing staff had been aware of those behaviors and pain in her knees with movement and transfers. *She had a history of pain in her knees, but recently that pain had become worse causing a decline in her transfer and ambulating 	F 309	<p>Resident has history of stuttered words such as "I can't, I can't" or "no, no, no" which is a behavior related to her diagnosis of dementia with behavioral disturbances and not pain.</p> <p>Documentation from staff and family supports this observation.</p> <p>Care Plan has been updated under behaviors and pain to reflect the interpretation of resident's vocalization.</p> <p>On 10/10/2014 facility completed a Pain Assessment on Resident 4 that revealed pain management plan of care was effectively meeting resident's needs.</p> <p>Resident # 4 does have a pattern of accepting medications PRN (as needed). Documentation shows that resident has only accepted medication for PRN pain medications when she has refused scheduled</p>	

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F 309	<p>Continued From page 14 capabilities.</p> <p>*The staff had been directed to use the sit-to-stand transfer aide or a one person stand/pivot transfer with her.</p> <p>*The majority of the staff had started to use the sit-to-stand transfer aide due to the resident's increase in anxiety and discomfort during transfers.</p> <p>Review of resident 4's current care plan revealed: *A focus area: "I have pain related to arthritis of knees" with a start date of 2/26/15. *A goal for that focus area: "I wish to have my pain addressed through my next review." *Interventions and approaches for that focus area were: -"Please administer pain medications per physician orders." -"Please ask me about my pain level when you are providing care to me and encourage me to report any pain I am experiencing to staff." *No non-medication interventions had been listed for the staff to provide and offer the resident for discomfort from knee pain.</p> <p>Review of resident 4's medication administration record from March 2015 through May 2015 revealed: *March 2015: -Could have had PRN Tylenol 62 times for pain. -Had been given PRN Tylenol once out of those 62 times for pain. Her pain level had been documented at a five. -Could have had PRN Tramadol 124 times for pain. -Had been give PRN Tramadol once out of the 124 times for pain. Her pain level had been documented at a seven. *April 2015:</p>	F 309	<p>medications of Tylenol and/or Tramadol.</p> <p>Resident #4's scheduled and PRN (as needed) pain medication do effectively manage residents discomfort. Physician has reviewed pain management plan on numerous occasions with no changes made and states current medications and plan of treatment are appropriate and pain is managed.</p> <p>Review of eMar and times available to have PRN pain medications reflect that on 3/4/2015 resident refused scheduled medications and later complained of bilateral knee pain as a 5 (0 to 10 scale) so PRN medication was administered.</p> <p>On 3/18/15 resident refused scheduled medications and later complained of bilateral knee pain as a 7 so PRN medication was administered.</p> <p>On 4/2/15 resident</p>	

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F 309	<p>Continued From page 15</p> <ul style="list-style-type: none"> -Could have had PRN Tylenol 60 times for pain. -No documentation to support she had been offered or given PRN Tylenol during April for pain. -Could have had PRN Tramadol 120 times for pain. -Had been given Tramadol once out of the 120 times for pain. Her pain level had been documented at a zero. *May 1, 2015 through May 18, 2015: there had been no documentation to support she had been given any PRN Tylenol or Tramadol for pain and discomfort. *For those three months there had not been any follow-up documentation provided to support the effectiveness of those PRN pain medications when they had been given to the resident for pain. <p>Interview on 5/20/15 at 9:00 a.m. with the MDS coordinator and assistant director of nursing (DON) revealed:</p> <ul style="list-style-type: none"> *The MDS coordinator: <ul style="list-style-type: none"> -Had been responsible for the pain assessments. -Could not support why there had been differences with the interviewing process and documentation for resident 4's pain level for her current annual MDS assessment. -Had not been sure of her role or the expectations after the interviewing process with the resident when there had been complaints of pain. She stated "What do you think I should have done." She offered no response when this surveyor asked her what the MDS manual directed her to do or what the provider's process was. *They agreed that anxiety with grimacing, groaning, and voicing "I can't, I can't, I don't know" were all signs of pain. *They had been aware resident 4: <ul style="list-style-type: none"> -Had arthritis in her knees. 	F 309	<p>refused scheduled pain medications and complained of pain so PRN medication was administered.</p> <p>For the time period 5/1/15 through 5/18/15 resident did not refuse scheduled medications and therefore did not need PRN medications.</p> <p>Documentation for effectiveness of PRN medication is located on the eMAR. This information was given to surveyor to review at time of survey.</p> <p>DON/Clinical Coordinators will complete PAINAD Assessment (a specific pain scale for people with dementia) for Resident 4 by 6/12/15. Physician will be notified of results and Care plan will be updated as appropriate.</p> <p>Physician has reviewed resident's plan for behaviors and discomfort on numerous occasions with no changes made and states current</p>	

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F 309	<p>Continued From page 16</p> <p>-Had pain and became anxious with any type of movement involving her knees.</p> <p>-Received scheduled Tylenol 1,000 mg twice a day for pain since 6/29/13.</p> <p>-Had recently been declining, and the pain in her knees was making it more difficult for her to ambulate and transfer.</p> <p>*They had thought her pain was managed effectively with the current physician's orders for pain management.</p> <p>*They had stated "She only has pain with movement, when she is not moving or at rest, she is fine."</p> <p>*No comment or response had been given when this surveyor asked if the family or physician had any concerns regarding her pain management and recent decline.</p> <p>Interview on 5/20/15 at 3:10 p.m. with the DON revealed she had not been aware resident 4 had been experiencing an increase in her pain. She had stated "This is the first I have heard of it." No further comment or response had been offered from the DON regarding the pain management for resident 4.</p> <p>Review of the provider's September 2014 Pain Assessment and Management policy revealed: *Purpose "The purposes of this procedure are to help the staff identify pain in the resident, to develop interventions that are consistent with the resident's goals and/or needs and address the underlying causes of pain." *Procedure: -"The pain management program is based on a facility-wide commitment to resident comfort." -"Pain management is defined as the process of alleviating [decreasing] the resident's pain to a level that is acceptable to the resident and is</p>	F 309	<p>medications and plan of treatment are appropriate.</p> <p>DON will review current treatment plan with facility Medical Director as well as the attending Physician to ensure that Resident #4's plan of care is appropriate.</p> <p>Additional information is being provided to clarify accounts of surveyor conversations with staff which reflect that resident's pain is under control.</p> <p>Education of all nursing staff on the Pain policy as well as non-pharmacological interventions will be completed by DON or designee at the nursing staff meeting scheduled for 6/17/2015.</p> <p>The Administrator or designee will in-service the Interdisciplinary Team regarding the Pain policy as well as non-pharmacological interventions by 06/17/15.</p>		

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F 309	Continued From page 17 based on his or her clinical condition, established treatment goals and that includes resident's function." -"Additionally, on an ongoing basis, appropriate follow up and assessment will be given when there is a significant change in a resident's condition, when there is an onset of new pain or increased pain, and if there is a change in the resident quality of life." *Recognizing pain: -"When applicable, observe the resident during rest and movement for verbal and non-verbal indications of signs of pain." -"Address the resident if they are experiencing pain to note signs that may include verbal expression, facial expression, behaviors, physical limitations, changes in condition." -"Review medication administration to determine how often resident requests or receives pain medication and to what extent the administered medications relieve the residents pain." **"During the comprehensive pain assessment gather the following information as indicated from the resident (or legal representative): -History of pain and its treatment, including pharmacological [medication] and non-pharmacological interventions. -Assess pain using a consistent approach and a standardized pain assessment instrument as appropriate to the resident's cognitive level. -Discuss with the resident (or legal representative) his or her goals for pain management and satisfaction with the current level of pain control."	F 309	Administrator/DON or designee will audit medication records for Resident 4. Findings will be reported monthly to QA Committee by Administrator/DON or designee for further direction or steps. Administrator/DON or designee will audit MDS' as dictated by the MDS schedule to ensure residents who trigger for pain have appropriate and effective pain management interventions in place. Findings will be reported monthly to QA Committee by Administrator/ DON or designee for further direction or steps.	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		

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F 314	<p>Continued From page 18</p> <p>resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review, care plan review, and policy review, the provider failed to:</p> <ul style="list-style-type: none"> *Ensure four of four sampled residents (5, 6, 7, and 8) who had been admitted to the facility without a pressure ulcer did not develop one. *Accurately use the Braden Scale for Predicting Pressure Ulcer Risk assessment tool (a form to assess the resident's risk for development of pressure ulcers) for two of four sampled residents (6 and 7). *Ensure individualized preventative measures were care planned and implemented for four of four sampled residents (6 and 7). *Ensure pressure ulcer documentation was completed according to the provider's policy for four of four sampled residents (5, 6, 7, and 8). <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of resident 6's medical record revealed: <ul style="list-style-type: none"> *A re-admission from the hospital date of 1/26/15. *Diagnoses included dementia (forgetfulness), history of falls, osteoporosis (weak bones), anorexia (eating disorder with weight loss), and debility (weakness). 	F 314	<p>F314 <u>The facility does ensure that residents who admit without pressure sores do not develop pressure sores unless the individual's condition demonstrates they were unavoidable.</u></p> <p>Resident 6 admitted to the facility on 1/26/15 following a hospital stay where he was treated for a UTI with Sepsis (inflammation throughout the body caused by infection) but was not admitted to the ICU (intensive care unit) due to code status of DNR/DNI (do not resuscitate/do not incubate) and conservative management.</p> <p>Resident 6 continued to be treated for a UTI following admission to facility and continued on antibiotics.</p>	7/19/15	

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F 314	<p>Continued From page 19</p> <p>*He had a Brief Interview for Memory Score (BIMS) (memory test) score of three on his 2/1/15 significant change Minimum Data Set (MDS) assessment, that revealed he had severely impaired cognition (memory).</p> <p>*He had required extensive assistance of one staff member for transfers, moving in bed, toileting, and personal hygiene.</p> <p>*He had been at risk for skin breakdown and had a current facility acquired pressure ulcer (an area of injured skin from too much pressure) to his buttocks.</p> <p>*He had a history of other pressure ulcers.</p> <p>Review of resident 6's interdisciplinary notes revealed:</p> <p>*A 1/26/15 admission nursing note did not mention any red or open areas to his skin.</p> <p>*A 1/27/15 medicare nursing note mentioned "some light redness noted to buttocks/rectal area, calmoseptine oint [type of ointment used for skin protection] used BID [twice a day]."</p> <p>*A 2/26/15 significant change in status nursing note stated "he has required weight bearing assist of 1 staff for bed mobility, transfers, locomotion [moving about] in wheelchair, dressing, toileting, hygiene...He does not routinely alert staff to his needs so his needs are anticipated...He is at risk for pressure ulcers and other skin problems but does not have any areas of pressure."</p> <p>*A 3/9/15 skilled nursing note stated "noted unstageable ulcer [type of pressure ulcer covered in slough (yellow, tan, gray, green, or brown drainage) and the depth is unable to be determined] to lower left buttock 0.7 cm [centimeter (unit of measurement)] by 2.0 cm, wound bed covered with yellow slough,...dressing applied per facility protocol except Santyl [type of</p>	F 314	<p>As noted by History and Physical from hospital, Resident 6 also had past medical history of Chronic Kidney Disease (acute renal failure stage II), CHF (chronic heart failure), atrial fibrillation, and hypotension. In summary, Resident 6 was severely deconditioned upon admission to facility.</p> <p>Resident #6 was assessed on admission and due to his potential for pressure ulcers related to limited mobility, incontinence, fragile skin and diagnosis preventative measures were put into place. Resident has a pressure reducing mattress, air overlay and a ROHO cushion in his wheelchair. Resident #6 is provided skin treatments with Tena moisture barrier cream and appropriate Tena absorbing products. Resident also received calmoseptine moisture barrier cream.</p>	

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F 314	<p>Continued From page 20 ointment used to remove the slough] d/t [due to no supply." *A 4/21/15 skilled nursing note stated "stage 3 [type of pressure ulcer that was a full thickness of skin tissue loss] pressure noted to lower right buttock...center is deep red, surrounded by white and yellow slough...treated per facility protocol." *Another 4/21/15 skilled nursing note stated "stage 3 pressure ulcer noted to posterior (back) scrotum, wound bed 100% covered with yellow slough,...treated per skin protocol." *A 4/28/15 skilled nursing note stated the left lower buttocks area was healed. *Another 4/28/15 skilled nursing note stated the area to the scrotum was healed.</p> <p>Review of resident 6's following medication and treatment administration records (MAR/TAR) related to skin treatments revealed: *February 2015: -Calmoseptine ointment to sores on buttocks twice daily; documented on 2/21/15 through 2/25/15. -Calmoseptine ointment for preventative care to buttocks twice daily; documented on 2/26/15 through 2/28/15. -Dressing to the right crease of the buttocks to be changed PRN (as needed) for soilage; start date 2/25/15. There was no documentation to show it had been completed. *March 2015: -Calmoseptine ointment for preventative care to buttocks twice daily continued. -Dressing change to unstageable pressure ulcer on lower left buttock every day, apply Santyl to wound bed, cover with hydrogel, apply skin prep to surrounding tissue, and cover the whole area with a bordered foam every day; documented on 3/9/15 through 3/12/15, and 3/14/15 through</p>	F 314	<p>Resident is able to change and control body position while in bed and in his wheelchair.</p> <p>Resident #6 was admitted on 1/26/15 with a noted reddened area to buttocks. Calmoseptine ointment (used for skin protection) was applied to skin BID (twice a day). 3/9/15 resident #6 was assessed as having an unstageable ulcer to his left buttock and with interventions in place healed on 4/28/15. Resident has a pressure reducing mattress, air overlay and a ROHO cushion in his wheelchair. Resident #6 is provided skin treatments with Tena moisture barrier cream and appropriate Tena absorbing products. Resident also received calmoseptine moisture barrier cream.</p>	

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F 314	<p>Continued From page 21</p> <p>3/29/15. Additional notes indicated the Santyl was not available on 3/10/15, 3/12/15, and 3/16/15.</p> <p>*April 2015:</p> <ul style="list-style-type: none"> -Calmoseptine ointment for preventative care to buttocks twice daily continued. -Assess unstageable pressure ulcer to lower left buttock and/or dressing to it every shift; documented on 4/1/15 through 4/28/15. -Dressing change to unstageable pressure ulcer on lower left buttock every day, apply Santyl to wound bed, cover with hydrogel, apply skin prep to surrounding tissue, and cover the whole area with a bordered foam every day; documented on 4/1/15 through 4/11/15, 4/13/14, 4/14/15, and 4/16/15 through 4/27/15. Additional notes indicated the treatment was not administered on 4/3/15 since he was up in the chair all day, on 4/4/15 and 4/10/15 he refused to lay down, and on 4/16/15 the nurse used a spot dressing instead. -Assess dressing to stage 3 ulcer on right lower buttock every shift. That had been documented on 4/21/15 through 4/30/15. -Change dressing to stage 3 ulcer on right lower buttock two times a week on bath days per protocol; documented on 4/23/15, 4/26/15, and 4/30/15. -Assess dressing to stage 3 ulcer on posterior scrotum every shift; documented on 4/21/15 through 4/29/15. -Change dressing to stage 3 ulcer on posterior scrotum two times a week on bath days per protocol; documented on 4/23/15 and 4/26/15. <p>*May 2015:</p> <ul style="list-style-type: none"> -Calmoseptine ointment for preventative care to buttocks twice daily continued. -Change dressing to stage 3 ulcer on right lower buttock two times a week on bath days per 	F 314	<p>4/21/15 Resident #6 was assessed as having a stage 3 pressure ulcer to scrotum that was healed by 4/29/15.</p> <p>4/21/15 Resident #6 was assessed as having a stage 3 pressure ulcer on right lower buttock and treatment is being continued.</p>	

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F 314	<p>Continued From page 22 protocol; documented on 5/3/15. -Assess dressing to stage 3 ulcer on right lower buttock every shift; documented on 5/1/15 through 5/5/15. -Change dressing to unstageable ulcer on right lower buttock daily. Cleanse with normal saline, apply nickel thick layer of Santyl to the wound bed, skin prep to the surrounding area and cover with a bordered foam every daily; documented on 5/4/15 through the present time. -Assess dressing to unstageable ulcer on right lower buttock every shift; documented on 5/5/15 through the present time.</p> <p>Review of resident 6's following skin assessment forms that were completed by nursing revealed: *On 2/25/15 the site was the right gluteal fold: -It was not listed as pressure. -Described as a small dime length area of sheared skin at the crease of the right buttocks where the resident's incontinence brief appeared to have rubbed against the area. -The area resolved 2/26/15. *The 3/9/15, 3/15/15, 3/22/15, 4/5/15, 4/19/15, and 4/26/15 forms had been for the left lower buttock. These forms revealed: -Description: unstageable pressure ulcer, with yellow slough, and red edges. -The treatments had been documented inconsistently. -On 3/9/15 it measured 0.7 cm by 2.0 cm. -Measurements were not listed for 3/15/15 and 3/22/15. -On 4/5/15 it measured 0.1 cm by 0.1 cm. -On 4/19/15 it measured 0.06 cm by 0.05 cm. -There had been no form for the week of 3/29/15 through 4/4/15 or 4/12/15 through 4/18/15.. -The area healed on 4/28/15. *A 4/21/15 form for the scrotum revealed:</p>	F 314	<p>2/25/15 Shear to right crease of buttocks for Resident #6 was healed by 2/26/15. Documentation shows that dressing changes were not needed on 2/25/15 due to dressing not being soiled .</p>	

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F 314	<p>Continued From page 23</p> <p>-It was a stage 3 pressure ulcer to the posterior scrotum, covered with yellow slough, and red tissue surrounding.</p> <p>-It measured 0.8 cm by 0.2 cm.</p> <p>-The treatment was listed as "per skin protocol."</p> <p>-The area healed on 4/29/15.</p> <p>*The 4/21/15, 4/23/15, 4/30/15, 5/1/15, 5/7/15, and 5/14/15 forms had been for the right lower buttock These forms revealed:</p> <p>-On 4/21/14 the area was stage 3, the center was deep red, surrounded by white and yellow slough, and it measured 3.0 cm by 2.9 cm.</p> <p>-On 4/23/15 the area was stage 3, the edges were rough, and it measured 3.9 cm by 3.1 cm.</p> <p>-On 4/30/15 the area was unstageable due to slough, it measured 3.5 cm by 2.4 cm, and the treatment was hydrogel and a bordered foam dressing.</p> <p>-On 5/1/15 the area was unstageable and measured 3.1 cm by 1.9 cm.</p> <p>-On 5/7/15 the area was unstageable and measured 2.8 cm by 2.0 cm.</p> <p>-On 5/14/15 the area was unstageable and measured 2.2 cm by 2.0 cm.</p> <p>*The descriptions and treatments on the forms varied.</p> <p>*On all the above skin assessment forms there was an entire section that was not completed and listed as "inapplicable." This area had included items such as: nutrition hydration intervention, ulcer care, preventative protective skin care, date physician notified, time physician notified, type of pressure relieving mattress, responsible party notification date and who was notified, and turning and repositioning program.</p> <p>Interview on 5/20/15 at 10:15 a.m. with the DON and administrator regarding resident 6's skin assessment forms revealed:</p>	F 314	<p>Facility uses a comprehensive software package from a national company that includes a skin condition form. The facility uses this form along with a skin condition protocol checklist, skin condition tracking sheet that is updated weekly and guidelines from American Medical Technologies (AMT) to ensure there is no conflicting information in the chart. The facility intentionally left areas of the skin condition form found in the software blank as those areas are not applicable to facility practice. Copies of the skin condition protocol checklist as well as AMT guidelines were reviewed and given to surveyors at the time of the survey.</p>	

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F 314	<p>Continued From page 24</p> <p>*The DON was aware the forms were not completely filled out.</p> <p>-She did not want the nurses to fill out that section, because it would not go anywhere.</p> <p>-She felt those items would have been listed in other areas of the documentation.</p> <p>-She agreed there had been differences in documentation by different nurses.</p> <p>*A charting or documentation policy was requested.</p> <p>-The DON stated there was no specific policy.</p> <p>-She further stated they had done ongoing education and audits on the documentation.</p> <p>Review of resident 6's following physician's orders revealed:</p> <p>*A 2/25/15 fax sent to the physician, "resident has small dime lengthed area to crease below right buttocks where top layer of skin appears to have sheared off...area is where attends meets the skin and appears due to attends rubbing against area...will continue to monitor."</p> <p>-Certified nurse practitioner signed and wrote "discussed with nurse - healing."</p> <p>*A 3/9/15 fax sent to his physician to update on the unstageable ulcer to his left lower buttocks.</p> <p>-Physician ordered "agree with above wound care, aggressively pursue off loading and pressure reduction left buttock, avoid his sitting on this for prolonged periods, shift weight/posture every 30 minutes when sitting up until healed."</p> <p>*A 3/11/15 dietitian recommendation: one packet Juven supplement twice a day, encourage oral fluids and foods, place on red glass program (special program for nutritionally at risk residents), multivitamin with minerals and zinc daily, add calorie booster/protein boosters. Noted by the physician on 3/13/15.</p> <p>-Additional dietitian comments stated "has</p>	F 314		

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F 314	<p>Continued From page 25</p> <p>increased needs due to unstageable pressure ulcer to left buttock." *A 5/4/15 fax sent to physician: updated on the unstageable ulcer to his right lower buttock; requested to use Santyl daily. -Physician wrote "I agree with wound care plan above, offloading off the area, no prolonged sitting, 1 hour at a time."</p> <p>Interview on 5/20/15 at 10:15 a.m. with the DON and the administrator revealed: *The DON agreed the physician had written the above orders. -She agreed that physician order "No prolonged sitting, 1 hour at a time" was still active at this time.</p> <p>Review of resident 6's 2/1/15 significant change MDS assessment revealed: *He required extensive assistance of two staff for moving in bed, transfers, toileting, and personal hygiene. *He was frequently incontinent (unable to control) of urine.</p> <p>Review of resident 6's 2/23/15 significant change MDS assessment revealed: *He required extensive assistance of one staff for moving in bed, transfers, toileting, and personal hygiene. *He was frequently incontinent of urine and bowel.</p> <p>Review of resident 6's 2/1/15 and 2/23/15 Care Area Assessment (CAA) summary revealed: *He triggered (identified at risk) for pressure ulcer. *The progress note stated he was at risk for pressure ulcers. He did not have any areas of</p>	F 314		
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F 314	Continued From page 26 concern. They would continue to care plan to keep the direct care staff aware of his needs. Review of resident 6's Braden Scale assessments from re-admission on 1/26/15 through the present time revealed: *On 2/2/15: -Moisture score two, indicated very moist skin. -Activity score two, indicated was chairfast (unable to bear own weight and/or must be assisted into chair or wheelchair). -Mobility score two, indicated was very limited (made occasional slight changes in position but unable to make frequent or significant changes on own). -Nutrition score three, indicated nutrition was adequate (ate over half of most meals). -Friction and shear (during a move the skin would slide against another surface) score two, indicated a potential problem. -Total score Wada fourteen. *On 2/9/15: -Moisture score three, indicated occasionally moist skin. -Activity score two. -Mobility score four, indicated no limitation (was able to make major and frequent changes in position without assistance). -Nutrition score two, indicated his nutrition was probably inadequate. -Friction and shear score was two. -Total score was seven. *On 2/16/15: -Moisture score one, indicated constantly moist skin. -Activity score two. -Mobility score four. -Nutrition score three. -Friction and shear score two.	F 314	Braden Scale is used by the facility for predicting pressure sore risk. The Braden Scale is conducted on admission, once a week for 4 weeks and quarterly thereafter. The Braden Scale scoring ranges from 6 to 23. The lower the score the higher the risk. The level of risk dictates the interventions strategies that should be used. At Risk (Braden score 15-18); Moderate Risk (Braden score 13-14); High Risk (Braden Score 10-12); Very High Risk (Braden Score 6-9). Resident #6 had Braden scores of 14, 16, and 17. This placed Resident #6 AT RISK. Interventions for residents noted to be AT RISK per Braden Scale Recommendations include the use of pressure-redistribution surfaces and to manage moisture, nutrition, friction, and shear. The interventions and recommendations are to help the resident be as active as possible. The Braden Scale, when	

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F 314	<p>Continued From page 27</p> <p>-Total score was sixteen. *On 2/25/15: -Moisture score two. -Activity score two. -Mobility score four. -Nutrition score three. -Friction and shear score two. -Total score was seventeen.</p> <p>*The bottom of the assessment had a section to give a score of 1 to 4 for a diagnosis that may influence tissue integrity. There was a score of 0 in that area for all the dates listed above. *The form indicated a score total of 12 or less would make them high risk for pressure ulcer development.</p> <p>Interview on 5/21/15 at 8:55 a.m. with LPN A and the MDS nurse revealed: *The MDS nurse agreed the AA were triggered from the MDS assessment on each resident to identify risk areas. -If a CAA was triggered for a resident she would ensure the care plan was updated and write a progress note. *For a pressure ulcer CAA the care plan should have had: kind of mattress, how the skin was monitored, notify the nurse of skin changes, kind of cushion in the wheel chair, and repositioning as appropriate. -She stated there was no specific repositioning program she would put on the care plan. *If the resident had a pressure ulcer the care plan should have had nutrition recommendations, an air overlay on the bed, if the wheel chair cushion needed to be changed, and physical therapy involved. *She stated she felt the Braden score of seventeen for resident 6 on 2/25/15 was correct. -She agreed a score of four for mobility that</p>	F 314	<p>completed, is reflective of a very specific date and time and is subject to change based on the resident's current condition and assessment.</p>		

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F 314	<p>Continued From page 28</p> <p>indicated he had no limitation, when he was coded as extensive assist on his MDS would not have been accurate.</p> <p>-When asked about the score of three for nutrition that indicated he had adequate nutrition she felt that was the correct score. She agreed he had a diagnosis of anorexia, had a history of weight loss, and not eating well.</p> <p>*They agreed resident 6 was at high risk for pressure ulcers.</p> <p>*They agreed if a Braden score had been lower and indicated more risk for pressure ulcer development they might have changed the way they treated the resident.</p> <p>*They agreed the MDS, CAA, and Braden assessment would have indicated the specific care the resident needed.</p> <p>Random observations of resident 6 and his room from 5/19/15 at 8:25 a.m. through 5/21/15 at 8:05 a.m. revealed:</p> <p>*He used a wheelchair for getting around.</p> <p>-He was able to propel the wheelchair on his own.</p> <p>-He had a Roho (specialty) cushion in his wheelchair.</p> <p>*He had a pressure relieving mattress on his bed.</p> <p>-No air overlay was noted on his bed, as was indicated that he had on his care plan.</p> <p>*Staff had assisted him with transfers using the sit-to-stand lift (mechanical lift used to move a resident from one place to another).</p> <p>*He was incontinent of urine.</p> <p>*Staff assisted him with personal care including incontinence care.</p> <p>Observation and interview on 5/20/15 at 7:45 a.m. with LPN A and the MDS nurse during a dressing change to his right lower buttock revealed:</p>	F 314		

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F 314	<p>Continued From page 29</p> <p>*He had an unstageable pressure ulcer to the right lower buttock.</p> <p>*There was a scar to his left lower buttocks from a previous pressure ulcer.</p> <p>*There was no designated wound nurse.</p> <p>*The weekly measurements would have been done by the nurse that did the dressing change.</p> <p>*They had a wound consultant that visited once a month for recommendations.</p> <p>*LPN A would have contacted the consultant in between visits if needed.</p> <p>Review of resident 6's current care plan revealed:</p> <p>*A focus area: "I have potential for pressure ulcers related to limited mobility, incontinence, fragile skin," start date 2/26/15.</p> <p>-Intervention for that focus area: "I have a pressure-reducing mattress and a cushion in my wheelchair."</p> <p>*Focus area: "I have a pressure ulcer to my right lower buttock noted on 4/24/15. It is unstageable," start date 5/1/15.</p> <p>-Intervention under that focus area: "Please turn and reposition me as appropriate."</p> <p>-No intervention on how often he should have been repositioned.</p> <p>*Intervention under that focus area: "I have a pressure-relieving device air overlay, Roho cushion."</p> <p>*There was no mention on resident 6's care plan of his refusal of repositioning</p> <p>*There was no mention of the physician's order for no prolonged sitting, only one hour at a time.</p> <p>Random observations on 5/19/15 from 8:25 a.m. through 3:25 p.m. of resident 6 revealed:</p> <p>*He had been sitting in his wheelchair.</p> <p>*He had been to breakfast, activities, lunch, and wheeling himself throughout the facility during the</p>	F 314			

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F 314	<p>Continued From page 30 above timeframe.</p> <p>Interview on 5/19/15 at 3:20 p.m. with certified nursing assistant (CNA) J revealed she had taken resident 6 to the bathroom around 10:00 a.m. He had been in his wheelchair since that time. She further stated that would be normal for his day. She was aware he had a pressure ulcer.</p> <p>Observation and interview with CNA K on 5/19/15 at 3:25 p.m. of resident 6's transfer and personal care revealed: *She had used the sit-to-stand lift to transfer the resident to the toilet and back to his wheelchair. *He had been incontinent of urine, through his brief and his pants. -The cushion in his wheel chair had a wet spot where he had been sitting. *She performed incontinence care. *She usually worked in the evenings. *The evening staff normally toileted him before and after supper. *He liked to roam the hallways in his wheelchair. *Sometimes they assisted him to bed right away after supper and sometimes he stayed up in his wheelchair as late as 9:00 p.m. *He had a dressing in place to the right lower buttocks. *She was aware of the pressure ulcer on his buttocks and was unsure how long it had been there.</p> <p>Interview on 5/20/15 at 8:25 a.m. with CNA B regarding resident 6 revealed: *He normally would have gotten up for the day around this time. *He was active and liked to cruise around the facility in his wheelchair. *Sometimes he refused to lay down in bed.</p>	F 314			

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F 314	<p>Continued From page 31</p> <p>*She stated he should have been repositioned at least every two hours.</p> <p>Observation and further interview on 5/20/15 at 1:30 p.m. with CNA B of resident 6 revealed: *He was lying in bed. *He normally laid down after lunch. *She stated "he never argues about that. He likes to lay down at this time of day."</p> <p>Interview on 5/20/15 at 4:25 p.m. with LPN G revealed the staff should have toileted resident 6 every two hours and would normally have laid him down after supper. She stated sometimes he refused to lay down.</p> <p>Interview on 5/20/15 at 10:15 a.m. with the director of nursing (DON) and the administrator revealed: *Staff used the care plans to care for the residents. *Regarding resident 6's care plan and specifically the entry to "turn and reposition me as appropriate:" -The DON stated it was okay. -She further stated the CNAs knew what was expected related to turning and repositioning the residents through their education. -She did not feel the care plan needed a specific plan or schedule for repositioning since the staff had been educated during inservices and training. *They were asked to provide further documentation that the resident had refused repositioning or laying down. -No further documentation had been received by the end of survey. *When asked about how often a resident with a pressure ulcer on their buttocks should have</p>	F 314			

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F 314	<p>Continued From page 32</p> <p>been repositioned, they gave no direct answer. -The DON stated it depended on the resident, and the staff had been educated on how to care for the residents. -The DON agreed on 5/19/15 the resident had been sitting for longer than one hour as ordered by his physician. *They were asked to provide documentation to support repositioning had been completed by the CNAs. -No further documentation had been received by the end of survey. *The DON was unsure if the mattress the resident had on his bed currently was the one that was on at the time of re-admission to the facility. -She was unsure when or if the air overlay was removed from his bed. -She stated they had an air overlay available to use currently in the store room. *The DON stated when someone developed a pressure ulcer: -They would have immediately looked at what mattress they had and added an air overlay. -She would have gotten the dietary department involved in the nutrition. -She would have involved the pharmacy if needed. -She would have looked at what type of cushion was in the wheel chair. *She had been unsure of what type of cushion the resident had initially had on re-admission or when the Roho cushion had been added by therapy. *She agreed that the resident's Braden score was not accurate.</p> <p>Review of resident 6's 3/27/15 PT (physical therapy) - Therapist Progress notes revealed: *"...he does have quite thin skin and there is a wound on his bottom."</p>	F 314	<p>Resident #6's family has been contacted on his plan of care and the history of this resident. Family agrees with the doctor's and the facility's plan of care for resident. Family has vocalized that resident does not want to be bothered to move or be repositioned by staff and wants only to be left alone; he is happy scooting around in his wheelchair and is always repositioning himself in it. With Resident's diagnosis of anorexia, they acknowledge that he will be susceptible to pressure sores and know that he is in good hands.</p> <p>Resident #6's Attending Physician, who is also the facility Medical Director, has reviewed Resident's Plan of Care on numerous occasions in the past and has been contacted to review it again. Resident #6's plan of care is individualized to his needs and preferences. Staff continue to direct, offer and give options for resident to lie down in bed.</p>		

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F 314	<p>Continued From page 33</p> <p>*"We worked with nursing to add a Roho cushion to his w/c (wheel chair) and an air overlay mattress on his bed."</p> <p>Interview on 5/20/15 at 2:40 p.m. with the DON and LPN A revealed:</p> <p>*They agreed resident 6 had acquired his current pressure ulcer to the right lower buttock, the previous one to his left lower buttocks, and scrotum at the facility.</p> <p>*They agreed individualized preventative measures would be appropriate for residents at risk for pressure ulcers.</p> <p>*LPN A indicated the CNAs documented during their shift that they had reviewed the care plans.</p> <p>*They were asked to provide documentation of what prevention measures had been in place prior to resident 6 acquiring his first pressure ulcer on 3/9/15. No further documentation had been received by the end of survey.</p> <p>*They agreed the Braden assessment was a tool used to identify a resident's risk of pressure ulcer.</p> <p>-If the score was low and identified a resident at high risk for pressure ulcer then the management team would be alerted.</p> <p>-If the score was not accurate that would have changed how they would react.</p> <p>Surveyor: 32355</p> <p>2. Review of resident 7's medical record revealed:</p> <p>*An admission date of 3/27/15.</p> <p>*Diagnoses of dementia (forgetfulness), Alzheimer's (memory loss), history of falls, bursitis (swelling of the joints) of both hips, diabetes mellitus (DM) (unstable blood sugar levels) and atrial fibrillation (irregular heart beat).</p> <p>*He had a BIMS score of four indicating his memory recall had been severally impaired.</p>	F 314	<p>Therapy continues to assess the ROHO cushion to ensure its benefits to Resident #6.</p> <p>Resident #7 admitted to the facility on 3/27/15 with Diagnoses of dementia, right hip pain, atrial fibrillation, diastolic heart failure, anemia, coronary artery disease (CAD), hyperbilirubinemia, hypercholesterolemia, altered mental status.</p>		

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F 314	<p>Continued From page 34</p> <p>*He had required extensive assistance of one staff member for transfers, moving in bed, and toileting. *He had been working with therapy for strengthening and ambulation. *He had been at risk for skin breakdown with two current facility acquired pressure ulcers to his buttocks.</p> <p>Review of resident 7's 3/27/15 admission head-to-toe physical assessment revealed he had *Bruises in various locations. *No pressure ulcers. *A history of fractures and falls with a recent change in his ability to move around.</p> <p>Review of resident 7's 3/27/15 admission interdisciplinary notes revealed: **"He came from [hospital name] with diagnosis altered mental status [confused], possibly sundowning [increased confusion in the later afternoon and evening], superimposed [added to] on chronic dementia, stable right hip pain." *He had a large bruise to the top of his right hand and a dry area to the inner part of his right heel. *No documentation to support any pressure ulcers had been identified on admission. **"Sit-to-stand lift (device to assist with transfers) and one assist for transfers." *He had used a wheelchair to get around. *He had required staff assistance with personal hygiene and toileting.</p> <p>Review of resident 7's Braden Scale Assessment (a scale of twelve or less indicated at risk for pressure ulcer development) forms revealed: *3/27/15, a score of twenty. *4/3/15, a score of twenty. *4/10/15, a score of twenty.</p>	F 314	<p>Resident #7 was assessed upon admission and it was found that he had a large bruise to the top of his right hand and a quarter size area was noted on inner right heel. Area scaly with small intact scab in the middle and area blanches.</p> <p>Resident #7's potential for pressure ulcers due to his diagnosis and incontinence was noted upon admission and a pressure reducing mattress on his bed. A cushion in his wheelchair and skin treatments Provided with Tena moisture barrier cream and appropriate Tena absorbing products. Resident wore booties while in bed for heel health. Heel area noted on admission healed by 4/15.</p> <p>Resident #7 is able to turn and reposition himself. Resident self propels his wheelchair for locomotion.</p>		

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F 314	<p>Continued From page 35</p> <p>*4/17/15, a score of twenty-two.</p> <p>*For all of the above he had been documented as:</p> <ul style="list-style-type: none"> -Independent with all body movements and repositioning. He could make major and frequent body changes in positioning without staff support. -Capable of moving in a bed and in a chair independently and had sufficient muscle strength to lift up completely during any change in position. <p>Interview on 5/20/15 at 2:45 p.m. with the DON confirmed the above Braden Scale Assessments had not been accurate. He had required staff assistance with mobility and transfers.</p> <p>Review of resident 7's 4/1/15 admission and 4/10/15 fourteen day MDS assessments revealed he had:</p> <ul style="list-style-type: none"> *Required extensive assistance with bed mobility, transfers, and toileting. *Been at risk for skin breakdown with no current pressure ulcers. *A pressure reducing mattress and cushion in his chair. *No turning or repositioning program in place. <p>Review of resident 7's 4/3/15 Care Area Assessment documentation by the MDS coordinator revealed:</p> <ul style="list-style-type: none"> *Pressure ulcer: -"[Resident name] is at risk for pressure ulcers." -"He does not currently have any areas of pressure." -"Continue to care plan to keep direct care staff aware of his risks and how to prevent." <p>Review of resident 7's 4/22/15 fourteen day MDS assessment by the MDS coordinator revealed:</p> <ul style="list-style-type: none"> **He has required weight bearing assist of 1 staff 	F 314	<p>Resident #7's Attending Physician has reviewed resident's plan of care and agrees with current interventions and treatments. Resident is on a Red Glass Program to encourage fluid intake. Resident #7 continues to be on a high nutrition diet. Staff continue to direct, offer and give options to lie down in bed as well as give Resident #7 options on his personal preferences of how often he wants to be reminded to reposition himself when resting in bed.</p>	

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F 314	<p>Continued From page 36 for bed mobility, transfers, toileting, hygiene, and bathing." *He has started to ambulate short distances with walker, gait belt (device to assist with transferring a resident), and staff assistance of one."</p> <p>Observations on 5/19/15 from 1:00 p.m. through 4:00 p.m. of resident 7 revealed: *He had been laying on his bed sleeping. *There had been no air overlay covering his mattress. *He had been laying on his back during that entire time with his heels and coccyx (tailbone) resting directly on the mattress. No repositioning devices had been observed to relieve pressure from his coccyx or feet while at rest such as pillows or wedges. *No observations of the staff attempting to reposition him off of his back and relieve pressure from his coccyx and heels.</p> <p>Interview on 5/21/15 at 9:20 a.m. with licensed practical nurse (LPN) F revealed all residents should have been repositioned every two hours. She had been unsure if it was acceptable for resident 7 to lay in one position for greater than two hours. She would have to ask the director of nursing (DON) if that was acceptable.</p> <p>Observation on 5/21/15 from 7:30 a.m. through 8:30 a.m. of resident 7 revealed: *He had been laying on his bed sleeping. *There continued to be no air overlay covering his mattress. *He had been laying on his back with both of his legs dangling over the edge of the bed. *His coccyx had been laying directly on the mattress.</p>	F 314			

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F 314	<p>Continued From page 37</p> <p>Review of resident 7's weekly skin assessment form regarding his stage 2 pressure ulcer to his coccyx revealed on: *4/27/15 he had acquired a stage 2 pressure ulcer (outer layer of the skin was missing) to his coccyx. *5/1/15 the stage 2 pressure ulcer on his coccyx had worsened and was now a stage 3 (a small opening underneath of the skin. *5/11/15 he continued to have a stage 3 to his coccyx. *There was no documentation to support the pressure ulcer to his coccyx had been assessed by the nursing staff during the week of 5/3/15 through 5/9/15 for worsening or healing conditions, and was free from signs and symptoms of infection.</p> <p>Review of resident 7's weekly skin assessment form regarding his stage 2 pressure ulcer to the left of his coccyx revealed on: *5/1/15 he had acquired a second pressure ulcer to his bottom. The pressure ulcer had been assessed and documented as a stage 2. *5/11/15 he continued to have a stage 2 to the left of his coccyx. *There was no documentation to support the pressure ulcer to his coccyx had been assessed by the nursing staff during the week of 5/3/15 through 5/9/15 for worsening or healing conditions, and was free from signs and symptoms of infection.</p> <p>All of the above reviewed skin assessments revealed the following areas were documented as "inapplicable" (did not apply): *Pressure relieving bed. *Pressure relieving chair. *Turing and repositioning program.</p>	F 314		

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F 314	<p>Continued From page 38</p> <p>*Nutritional health drinks and vitamins to promote healing.</p> <p>*Ulcer care.</p> <p>Review of resident 7's current care plan revealed:</p> <p>*A focus area: "I have a pressure ulcer to my coccyx noted on 4/27/15. It is a stage II with a start date of 5/1/15."</p> <p>*A goal under that area: "I would like to maintain or improve my pressure ulcer through my next review."</p> <p>*Interventions under that area were:</p> <ul style="list-style-type: none"> - "Please turn and reposition me as appropriate." - No documentation for staff to follow on how often they were to have repositioned him. - No instructions for the staff to offload (relieve pressure) at the sight of the wounds. - He was to have a pressure-relieving device air overlay and a w/c cushion. <p>*There had been no documentation to support he had:</p> <ul style="list-style-type: none"> - A new open area to the left side of his coccyx. - The stage 2 pressure ulcer on his coccyx had worsened and now was a stage 3. <p>Interview on 5/20/15 at 9:00 a.m. with the MDS coordinator, DON, and assistant DON revealed:</p> <p>*They confirmed resident 7 had acquired two pressure ulcers while under their care.</p> <p>*No response or answer had been provided when the surveyor asked for preventative measures that were to be used for residents who had been identified at high risk for skin break down.</p> <p>*They had no futher comment as to what "reposition as appropriate" should have meant for the staff who assisted resident 7 with her cares.</p> <p>The provider had not been able to supply this surveyor with any further documentation upon</p>	F 314			

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F 314	<p>Continued From page 39</p> <p>request to support appropriate preventative measures had been put in place to ensure resident 7 had not obtained two facility acquired pressure ulcers.</p> <p>Surveyor: 27473</p> <p>3. Record review for resident 5 revealed she had been admitted 3/19/15 following hospitalization for a fractured pelvis. She was identified at risk for potential of developing pressure ulcers related to her limited mobility, fragile skin, and thin body frame. Her BIMS score was three meaning she had severe cognitive (memory) impairment or did not fully understand instructions.</p> <p>Review of resident 5's skin assessment forms revealed inconsistent assessment dates when new skin concerns were identified.</p> <p>Review of resident 5's skin assessment form with body diagram revealed</p> <p>*On 3/20/15 at 12:07a.m.:</p> <ul style="list-style-type: none"> -category skin condition, other type, described as a small dime size area of sheering was noted to mid back just to the right of her spine. -the diagram showed it just above the buttocks. -wound bed is reddened, and does not blanch (change color when pressed), tender to touch, with no signs or symptoms of infection or drainage noted. -cleansed with normal saline, with hydrogel and a spot dressing applied. -surrounding skin was "normal for resident." -resident tolerated treatment well. <p>*On 3/31/15 at 12:55 p.m.:</p> <ul style="list-style-type: none"> -category skin condition, pressure ulcer type with the above diagram noted. -cleansed with normal saline, dried with guaze 	F 314	<p>Resident #5 admitted to the facility on 3/19/15 at approximately 4:00pm. Discharge diagnosis from the hospital included urinary tract infection (UTI), hypothyroidism, hypertension, incontinence and cataracts in addition to pubic ramus fracture. Skin assessment was completed upon admission and facility staff noted dime size area of sheering to mid back, 3 small scabbed areas to left of sheered area. To right of the spine mid back there is a dime sized pink area that skin is intact and it blanches. Nurse cleansed and dressed open wound and off loaded resident from these areas while in bed.</p> <p>Resident #5 skin was assessed on 3/19/15; 3/20/15, 3/21/15, 3/22/15, 3/23/15, 3/24/15, 3/25/15, 3/31/15, 4/2/15,</p>	

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F 314	<p>Continued From page 40 and a Tegaderm (type of dressing) spot dressing applied. The surrounding skin was "reddened." *On 4/7/15 at 12:29 p.m.: -category partial thickness wound, pressure ulcer type described as a small area to lower mid spine area, it had slough covering wound. -measured 1.2 centimeters (cm) in length with 1.3 cm width. -"a scant amount of yellow odorless drainage on the dressing." -cleansed with saline, surrounding skin treated with skin prep, hydrogel and nonborder foam applied. -surrounding skin was "pink and fragile." *On 4/14/15 at 3:54 p.m.: -category partial thickness wound, pressure ulcer type, described as a small pressure ulcer to lower mid spine with slough, a scant amount of yellow non-odorless drainage. -cleansed with normal saline, skin prep around wound, Santyl applied, hydrogel and bordered foam dressing. -area measured 1.3 cm in length and 1.3 cm wide.</p> <p>Continued review of resident 5's skin assessment form revealed: *On 3/21/15 at 11:03p.m.: -category partial thickness wound, pressure ulcer type, described as an area on the right side of the spine, mid back, with red, dry, non-blanchable wound bed. *On 3/31/15 at 4:39 a.m.: -category full thickness wound, pressure ulcer type, described as an unstageable pressure ulcer to the spine with 100 percent (%) slough to the wound bed. -area measured 1.0 cm in length and was 1.3 cm wide.</p>	F 314	<p>4/7/15, 4/14/15, 4/17/15, 4/21/15, 4/22/15, 4/23/15, 4/24/15, 5/2/15, 5/9/15, 5/15/15. Open areas on spine were healed on 4/22/15 and 5/16/15 respectively.</p> <p>Due to the resident #5's potential for pressure ulcers due to her limited mobility, thin frame, fragile skin and diagnosis, she has a pressure reducing mattress and air overlay on her bed. While in her wheelchair she has a pressure reducing cushion. Nursing personnel reposition resident regularly every couple of hours as noted by surveyor.</p> <p>Resident #5's Attending Physician, who is also the facility Medical Director, has reviewed resident's plan of care on numerous occasions in the past and continues to agree with the interventions and treatment. Resident's family is involved and agrees with the care that is being provided. Resident #5 is</p>	

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F 314	Continued From page 41 -cleansed per facility protocol. Hydrogel, skin prep and secondary dressing was applied. -surrounding skin was "red, fragile." -resident tolerated well. -air mattress overlay was on bed and a cushion in the wheelchair. -frequent turn and repositioning. *On 4/3/15 at 3:11 p.m.: -category full thickness wound, pressure ulcer type, noted as "unstageable pressure ulcer, cleansed and dressed per facility protocol." -area measured 1.3 cm in length and was 1.3 cm wide. -surrounding skin was "red fragile." -"turned q (every) 2 hours, air mattress on bed." *On 4/17/15 at 2:01 p.m.: -category full thickness wound, pressure ulcer type, described as "healing unstageable ulcer to right of spine, wound bed with 60% slough." -area measured 1.0 cm in length and was 0.7 cm wide. -Santyl to wound bed, covered with hydrogel gauze, secured with bordered foam. *On 4/21/15 at 12:40 p.m.: -category full thickness wound, pressure ulcer type, described as "full thickness wound with serous slough-pink in color at this time-no odor." -area measured 0.8 cm in length and 0.7 cm wide. -bathed, Santyl to wound bed, hydrogel gauze secured with border foam. *On 4/23/15 at 11:05 a.m.: -category full thickness wound, pressure ulcer type, described as "unstageable pressure ulcer with pink wound bed-serous drng-wound edge dark pink to reddened in color." -area measured 0.7 cm in length and 0.7 wide. -surrounding skin was "intact" and the wound edge was "dark pink to reddened."	F 314	encouraged to transfer from her wheelchair to a regular chair during meal times; continues on a high calorie diet; is on the Red Glass program to encourage fluids. Therapy continues to assess the wheelchair cushion to ensure its benefits to Resident #6.		

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F 314	<p>Continued From page 42</p> <p>-cleansed with normal saline, hydrogel dressing applied with border foam dressing.</p> <p>*On 4/24/15 at 3:33 p.m.:</p> <p>-category full thickness wound, pressure ulcer type, described as "healing unstageable pressure ulcer just right of mid-spine.</p> <p>-yellow serous drainage, lt amt. [light amount] Non-odorous.</p> <p>-surrounding skin pink. No sn [signs]/sx [symptoms] of infections."</p> <p>-area measured 0.7 cm in length and was 0.7 cm wide.</p> <p>-cleansed per facility protocol, Santyl, hydrogel, bordered foam applied.</p> <p>Continued review of resident 5's skin assessment form revealed:</p> <p>*On 4/17/15 at 2:58 p.m.:</p> <p>-category skin condition, other type, described as a "deep abrasion noted to left back around area of frequent adhesive from dressing to other wounds.</p> <p>-Area deep red, no drainage noted. Will treat with other wounds."</p> <p>*On 4/21/15 at 12:37 p.m.:</p> <p>-category skin condition, other type, described as "no drainage; bathed; hydrogel gauze w/border (with border) foam."</p> <p>*On 4/24/15 at 3:25 p.m.:</p> <p>-category skin condition, other type, described as "deep abrasion L (left) mid back, deep red without drainage. Will treat and monitor with other back wound."</p> <p>Random observations on 5/19/15 from 8:30 a.m. through 6:00 p.m. and 5/20/15 from 7:30 a.m. through 4:30 p.m. of resident 5 revealed she spent much of her time sleeping in bed. Her positions were changed regularly every couple of</p>	F 314		

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F 314	<p>Continued From page 43</p> <p>hours. She often appeared to be curled up in a ball on one side or the other.</p> <p>4. Closed (discharged) record review for resident 8 revealed she had been admitted on 12/22/14, following hospitalization for a fractured pubis (front portion of pelvis). She was identified at risk for potential of developing pressure ulcers related to her limited mobility. Her BIMS score was eleven, meaning she had moderate cognitive (memory) impairment but would be able to understand instructions. Her BIMS score at discharge was fifteen meaning she had no cognitive impairment and would fully understand instructions.</p> <p>Review of resident 8's skin assessment form with body diagram revealed: *On 1/11/15 at 10:38 p.m.: -category partial thickness wound, pressure ulcer type, described as "unstageable ulcer to right buttock, tender to touch, scant bleeding, unblanchable." -area measured 0.6 cm in length and was 0.6 cm wide. -Hydrogel gauze, non-bordered foam, secured with Tegaderm was applied. *On 1/11/15 at 10:43 p.m.: -category partial thickness wound, pressure ulcer type, -described as "stage 2 pressure ulcer to right buttock immediately adjacent to, on the medial side, of a unstageable ulcer, tender to touch." -area measured 0.5 cm in length and 0.3 cm wide." -Hydrogel gauze, non-bordered foam, secured with Tegaderm was applied. -Addition note at 10:00 p.m. indicated, "Noted on right buttock two pressure ulcers adjacent to each</p>	F 314	<p>Resident #8 has discharged from the facility so no further assessments/ interventions will be completed.</p> <p>Education of all nursing staff on skin assessment, Braden scale completion, and pressure ulcer prevention will be completed by DON or designee at the nursing staff meeting scheduled for 6/17/2015.</p> <p>DON or designee will review Braden Scores, skin assessments and care plans on those residents identified as high risk to ensure completion and appropriate interventions. Findings will be reported monthly</p>	

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F 314	Continued From page 44 other - unstageable, 0.6 cm x 0.6 cm, and stage 2 medial to it, 0.5 cm x 0.3 cm. Small amt [amount] of yellow slough noted to center of unstageable and scant amt of bleeding. Does not blanch. Center of stage 2 pink, unblanchable. Ulcers and surrounding area tender to the touch. Wound edges with flaky skin and surrounding skin red and unblanchable. Treatment initiated per protocol. Encouraged rsdt [resident] to offload (reposition self)." *On 1/26/15 at 3:32 p.m.: -category partial thickness wound, pressure ulcer type, -described as "Stage 2 pressure sore to right buttock, on medial side. Pinpoint. Non-tender to touch." -dressing changed to stage 2 pressure sore to right buttock, on medial side after her bath. It is pinpoint, non-tender to touch. -surrounding tissue is normal color and blanches. -Hydrogel and spot dressing. *On 1/28/15 at 2:21 p.m.: -category skin condition, other type, described as "Fragile skin noted to site of previous stage 2 ulcer, area is red, and pinpoint center with scant amt of bleeding. Another pink, sl [slight] raised, pinpoint area noted to the right and above rest of area, no drainage. All areas blanch." *On 1/28/15 at 2:33 p.m.: -separate interdisciplinary note indicates "Noted stage 2 pressure ulcer to right buttock healed. Area blanches, but remains red. Pinpoint center with scant amt bleeding noted. Pinpoint, pink, red area without drainage noted just above and the right of the rest of fragile area. -Skin conditions and EMAR [electronic medication administration record] updated." *On 2/6/15 at 6:34 a.m.: -category partial thickness wound, pressure ulcer	F 314	to QA committee by DON or designee for further direction or steps. DON and Clinical Coordinator will reeducate all nursing staff on documentation protocol on skin care/pressure ulcer procedure by 6/17/15 Administrator/DON or designee will audit all residents with pressure ulcers in the facility for weekly documentation and report findings to Nutrition Risk Weekly Committee Meeting for follow up and interventions. Care plan interventions will be reviewed, updated and individualized on an ongoing basis as dictated by the MDS schedule as needed based on updated changes to residents conditions and identified risk score. Administrator/DON or designee will audit all identified with risk care conference ID notes weekly to ensure care	

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F 314	<p>Continued From page 45</p> <p>type, described as "Stage 2 pressure ulcer to right buttock measuring 0.6 cm x 0.4 cm with epithelial (thin protective layer on exposed skin surface) tissue.</p> <p>-cleansed and dressed per facility protocol. Barrier cream applied to surrounding tissue.</p> <p>-Resident reports pain 4/10 [4 of 10 on a scale of 1 to 10 with 1 the least amount of pain and 10 the worst amount of pain] to area during dressing change.</p> <p>-medicated per emar.</p> <p>-air mattress offered and refused. Encouraged [name] to offload {reposition}area. Tolerated dressing change well.</p> <p>*On 2/11/15 at 3:42 p.m.:</p> <p>-category partial thickness wound, skin tears type, described as "small area below coccyx in right gluteal [buttock] crease with skin sheared off. Rough jagged edges."</p> <p>-Additional note indicated "Other nurse working on floor was changing dressing to resident's pressure area on right buttocks and when dressing removed, the edge of taped dressing pulled off a small amount of skin in right gluteal crease area causing skin tear to area. Unable to approximate [match] edges of skin tear and area cleansed and dressed per facility protocol. Will continue to monitor and anticipate needs."</p> <p>*On 2/18/15 resident 8 was discharged home.</p> <p>Surveyor: 32355</p> <p>Interview on 5/20/15 at 9:00 a.m. with the MDS coordinator, DON, and assistant DON revealed:</p> <p>*They had not been concerned about the preventative measures to ensure there had not been any skin breakdown. The DON had stated "But the outcome is good, they are healing."</p> <p>*The provider had no specific turning or repositioning program.</p>	F 314	<p>plans were reviewed, revised, individualized, and that resident/responsible party had opportunity to participate. Findings will be reported monthly to QA Committee by Administrator/DON or designee for further direction or steps.</p>	
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F 314	<p>Continued From page 46</p> <ul style="list-style-type: none"> *They had not been able to identify what "repositioning as appropriate" meant on the resident's care plans. *The staff would have used the care plans to care for the residents. *The MDS coordinator had been responsible for the reviewing and revising of the care plans. *When a resident had been able to move their legs, arms, and feet without assistance by the staff that had been considered a type of repositioning. *The DON had not expected the nursing staff to fully fill out the weekly skin assessment forms. She stated "I don't expect them to fill all those areas out. It would not go anywhere, it would not lead to anything." <p>Review of the provider's 1/7/15 Skin Care/Pressure Ulcer policy revealed:</p> <ul style="list-style-type: none"> *Purpose "To ensure skin concerns are addressed properly." *Procedure: <ul style="list-style-type: none"> - "Each resident will be evaluated for risk of skin breakdown upon admission and quarterly thereafter. The Braden form will be used. These results are shared with other departments as necessary." - "A plan to prevent skin breakdown will be initiated to meet the residents needs based on the results from the Braden Scale Assessment per protocol." - "Documentation of interventions will be noted in the resident care plan and communicated to staff." - "Evaluation and preventative measures should be documented in the resident's chart." - "Once a wound has been initiated, follow-up documentation will be completed weekly." 	F 314			

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F 314	<p>Continued From page 47</p> <p>Review of the provider's undated Skin Condition Charting Protocol checklist revealed: **"Upon discovery of a pressure ulcer: -Apply air mattress overlay to bed. -Instruct staff to offload location of ulcer."</p> <p>Surveyor: 27473 Per the provider's undated Skin Condition Charting Protocol Checklist and January 7, 2015, Skin Care/Pressure Ulcer Procedure once a wound assessment has been initiated, follow-up documentation was to have been completed weekly.</p> <p>Interview on 5/20/15 at 1:30 p.m. with the director of nurses and licensed practical nurse A confirmed it appeared they had not followed the policy about timely, weekly documentation once a wound or pressure ulcer had been identified.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, Mo, 2013, page 1195, revealed: "The first step in prevention is to assess the patient's (resident's) risk for pressure ulcer development. Plan on reducing or eliminating the identified risk factors."</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, Mo, 2013, page 1184, revealed: "Preventing pressure ulcers is a priority in caring for patients and is not limited to patients with restrictions in mobility. "Braden Scale, a widely used risk-assessment tool, is in the WOCN [wound ostomy certified nurse] guidelines (2010) as being a valid tool to use for pressure ulcer risk assessment. The Braden Scale was developed based on risk</p>	F 314		
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F 314	Continued From page 48 factors in a nursing home population and is composed of six subscales: sensory perception, moisture, activity, mobility, nutrition, and friction/shear. The total score ranges from 6 to 23; a lower total score indicates a higher risk for pressure ulcer development." Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, Mo, 2013, page 1196, revealed: "Assessment and documentation of a pressure ulcer needs to occur at least weekly, unless there is evidence of deterioration, in which case the nurse needs to reassess both the pressure ulcer and the patient's (resident's) overall management immediately. "A standard turning interval of 1-1/2 to 2 hours does not always prevent pressure ulcer development. Patients need repositioning on a schedule of at least every 2 hours if allowed by their overall condition." "Some patients are able to sit in a chair. Make sure to limit the total amount of time they sit to 2 hours or less... In addition, teach a mobile patient at risk for skin breakdown in a sitting position to shift weight every 15 minutes."	F 314		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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.	F 431	F431 <u>The facility does utilize the services of a licensed pharmacist. The facility does ensure all drugs and biological used in the facility are labeled appropriately. The facility does store all drugs and biologicals in separate locked compartments.</u>	6/30/15

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F 431	<p>Continued From page 49</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 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: 32355 Based on observation, interview, and policy review, the provider failed to ensure external and internal medications had not been stored together in two of two medication carts and in one of one medication room. Findings include:</p> <p>1. Observation on 5/20/15 at 11:20 a.m. of both medication carts revealed: *A tube of protective barrier ointment, two containers of Vaseline, three containers of triamcinolone cream (used for itching, swelling,</p>	F 431	<p>Facility practice is to utilize the bin (plastic basket) noted in surveyor comments as a receiving bin for medications delivered from the pharmacy. The medications in the bin are not placed in the medication or treatment cart until the nurse has verified all aspects of the medication are correct, i.e. resident name, name of medication, dosage, route (i.e. oral, topical), frequency, and must match all elements of the physicians order with no variance before being placed into the medication or treatment cart.</p> <p>On 6/5/2015 the DON met with the consultant pharmacist. The medication cart was reviewed and all medications were designated to a specific location in the medication cart and provided separate barriers.</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2015
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NAME OF PROVIDER OR SUPPLIER WESTHILLS VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 255 TEXAS ST RAPID CITY, SD 57701
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 431	<p>Continued From page 50 and skin irritation), five bottles of various types of medicated shampoo had all been stored with residents' oral medications.</p> <p>*Multiple bottles of Debrox ear drop (medication to remove ear wax) bottles for various unidentified residents had been stored together without individualized storage containers.</p> <p>*Multiple Nystatin bottles (powder to treat antifungal infections) had been stored loosely with residents' eye drop medications. The label on the Nystatin bottle read "Not indicated for oral or ophthalmic (eye) use."</p> <p>Interview on 5/20/15 at the time of the above observation with licensed practical nurse (LPN) F confirmed the topical and internal medications should not have been stored together. She agreed there had been the potential for cross-contamination from one resident to another.</p> <p>Interview on 5/20/15 at 11:30 a.m. with the director of nursing (DON) revealed: *She had depended on the pharmacist to check the medication carts for proper storage of all medications. *The pharmacist had just been in the facility and checked both of the medication carts last week. There had been no problem with the storage of the above medications at that time. *She had no concerns regarding the above observations.</p> <p>Surveyor: 35237 2. Observation on 5/20/15 at 11:20 a.m. of the medication room revealed: *A plastic basket in a cupboard contained the following residents' medications without some</p>	F 431	<p>Education of all nursing staff on medication storage will be completed by DON or designee by 6/19/15.</p> <p>Administrator/DON or designee will audit all medication carts weekly for 4 weeks and monthly thereafter to ensure medications are stored separately. Findings will be reported monthly to QA Committee by Administrator/DON or designee for further direction or steps.</p>	
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NAME OF PROVIDER OR SUPPLIER WESTHILLS VILLAGE HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 255 TEXAS ST RAPID CITY, SD 57701		
(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 431	<p>Continued From page 51</p> <p>type of barrier between them: -An inhaler, six bottles of various types of eye drops, one tube of pain relieving gel, one tube of hydrocortisone cream (type of steroid for the skin), one tube of terbinafine cream (type of antifungal) that had a warning on it for external use only.</p> <p>Interview at the same time as the above observation with LPN F revealed those medications typically were stored in the basket that way.</p> <p>3. Review of the provider's undated General Safety Control Policies revealed "External and internal medications must be kept in separate compartments of medicine cabinet." Upon request from the surveyor no other policy had been provided up until the end of the survey.</p>	F 431		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435033	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2015
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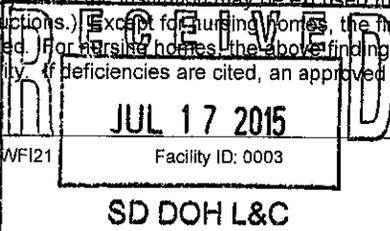
NAME OF PROVIDER OR SUPPLIER WESTHILLS VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 255 TEXAS ST RAPID CITY, SD 57701
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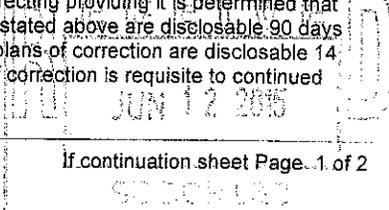
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/19/15. Westhills Village Health Care Facility was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiency identified at K051 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 6/30/15 telephone to facility CEO. LF/5000H/JJ	
K 051 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051	<u>K051</u> Maintenance Supervisor or designee will remove heating unit from the mechanical room by 6/30/15. * QA Committee will be notified upon completion of the work. LF/5000H/JJ	6/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>A. Saylor</i>	TITLE <i>Administrator</i>	(X6) DATE <i>6/10/15</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.


JUL 17 2015
 Facility ID: 0003
SD DOH L&C


JUN 12 2015
 If continuation sheet Page 1 of 2
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NAME OF PROVIDER OR SUPPLIER WESTHILLS VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 255 TEXAS ST RAPID CITY, SD 57701
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K 051	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure the fire alarm system was installed and maintained in appropriate condition required by NFPA 72 National Fire Alarm and Signaling Code at one randomly observed location (heat detector in mechanical room near laundry room). Findings include:</p> <p>1. Observation at 11:15 a.m. on 5/19/15 revealed a mechanical room for water heaters and fire sprinkler riser across from the laundry room. Further observation revealed a heat detector was installed on the ceiling of that room. That heat detector was installed approximately two feet away from a unit heater. That heat detector was not rated for high heat areas produced from unit heaters. Interview with the plant observation supervisor at the time of the observation revealed that unit heater was not used anymore, as it had been installed for prior purposes. He further indicated he would remove the unit heater.</p>	K 051		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2015
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NAME OF PROVIDER OR SUPPLIER WESTHILLS VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 255 TEXAS ST RAPID CITY, SD 57701
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S 000	<p>Initial Comments</p> <p>Surveyor: 27473 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 5/19/15 through 5/21/15. Westhills Village Health Care Facility was found in compliance.</p>	S 000		

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

A Saylor

TITLE

Administrator

(X8) DATE

RECEIVED
JUN 12 2015
SD DOH L&C

If continuation sheet 1 of 1