

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2015
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NAME OF PROVIDER OR SUPPLIER STRAND-KJORSVIG COMMUNITY REST HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261
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F 000	INITIAL COMMENTS Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/3/15 through 2/5/15 and from 2/10/15 through 2/11/15. Strand-Kjorsvig Community Rest Home was found not in compliance with the following requirements: F156 , F159, F167 , F248, F253, F279, F280, F281, F309, F314, F323, F329, F332, F353 , F356 , F371, F428, F441, F516, and F520. ODDHYME	F 000		
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal	F 159	F159 On 2/4/15, a pooled interest-bearing account was opened for all resident funds, including funds of \$50.00 or less. On 2/10/15, all resident funds held by facility were deposited into this account. A petty cash fund was established on 2/10/15. Resident requests of \$50 or less will be given from this fund, the transaction documented on the account transaction form and recorded on said resident ledger. Interest will be prorated per individual on the basis of end-of-quarter balance. Any request by a resident of \$50.00 or more will be honored within three banking days. The resident funds policy and form were revised on 2/28/15.	3/13/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shannon Schmidt</i>	TITLE <i>Administrator</i>	(X8) DATE 03/08/2015
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting, provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

MAR 30 2015

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F 159	<p>Continued From page 1</p> <p>funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on observation, interview, and account ledger review, the provider failed to ensure resident's personal funds in excess of \$50 had been held in an interest bearing account for twelve of twelve residents' trust fund accounts (4, 5, 6, 7, 11, 17, 21, 22, 23, 24, 25, and 26) reviewed. Findings include:</p> <p>1. Interview and observation on 2/4/15 at 3:15 p.m. with the business manager revealed resident's personal funds were kept in individual envelopes in a three-ring binder. The binder had been kept in a locked safe in the business office. The safe had been accessible by only the</p>	F 159			

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F 159	Continued From page 2 administrator and business manager. The business manager confirmed the resident's personal funds in excess of \$50 had not been kept in an interest bearing account. Review of the provider's account ledger of residents' personal funds dated 1/6/15 revealed cash amounts for the following residents: *Resident 4 - \$133.00. *Resident 5 - \$130.72. *Resident 6 - \$116.00. *Resident 7 - \$256.00. *Resident 11 - \$677.65. *Resident 17 - \$165.45. *Resident 21 - \$229.66. *Resident 22 - \$246.77. *Resident 23 - \$219.18. *Resident 24 - \$106.95. *Resident 25 - \$55.83. *Resident 26 - \$70.00. Interview on 2/10/15 at 11:10 a.m. with the administrator confirmed the residents' personal funds had not been kept in an interest bearing account as required.	F 159		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 32355	F 248	F248 For residents #3 and #6: The provider developed an individualized activity program and updated the care plan to reflect that if the resident does not attend group activities, devotions, and other activities listed on the monthly calendar, the staff will do structured 1:1 visits with the	3/13/2015

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F 248	<p>Continued From page 3</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure activities were developed based on residents' individual needs for two of nine sampled residents (3 and 6). Findings include:</p> <p>1. Review of resident 3's complete medical record revealed: *An admission date of 11/30/11. *Diagnoses of dementia (forgetfulness) with behavioral disturbances, glaucoma (poor eyesight), dysphasia (difficulty swallowing), bilateral (both) inguinal hernia (soft tissue protruding through the muscle) in his scrotal area, history of respiratory (lung) infections. *He had been placed on comfort care (end of life) on 1/19/15. *He had been dependent upon the staff to assist him with all of his activities of daily living (ADL) needs and to ensure mental stimulation was provided.</p> <p>Random observations from 2/3/15 through 2/5/15 of resident 3 revealed: *He remained in his room at all times except for meals. *When he was in his room he had been resting in his bed or up in his wheelchair (w/c). *When he was sitting in his w/c there had been a television (TV) turned on for auditory (hearing) and mental stimulation. *No other form of mental stimulation had been observed. *No one-on-one activity or visits had been observed from activities, nursing staff, or social services. *Staff had only been observed in his room during assistance with ADLs.</p>	F 248	<p>resident. The activity staff will document in each resident's activity calendar log the participation and attendance of the structured 1:1 visits and the weekly activities the resident attended. The Activities 1:1 Program policy and procedure was revised on 3/2/15.</p> <p>For all other potential residents: Residents identified with limited activity participation or socialization, an individualized activity program will be developed. The activity program will include structured 1:1 visits and small group or large group activities. The activity staff will document response, attendance and participation in the activity calendar log binder and update the care plan to reflect the preferred activities and visits. The 1:1 visit must also be documented in the 1:1 program binder.</p> <p>In-service: Education of activity staff on the policy for activity programs, 1:1 structured visits and care planning was provided to the activity staff by the administrator on 3-4-15.</p> <p>Audits: Audits will be completed to monitor that individualized activity programs have been developed for residents who have limited activity participation, or</p>	
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F 248	<p>Continued From page 4</p> <p>Review of resident 3's 9/2/14 care plan revealed: *A focus area stated: -"Alteration in activity level related to decreased ability to move, dementia manifested by needs to be taken to activities." -"Is unable to participate but does seem to enjoy music." -"Attends some activities but does not participate. Give one-to-one attention." *A goal area stated "Resident will attend music and special programs and not be disruptive though next 90 days." *An approach area stated: -"Resident enjoys music, group, devotions, one-to-one time." -"Small sensory group." -"One-to-one two times per week." -"Invite and assist resident as needed to attend activities of choice."</p> <p>Review of resident 3's Minimum Data Set (MDS) assessments revealed: *On the 8/28/14 annual assessment he liked to listen to music. *On the 11/20/14 quarterly assessment he enjoyed listening to music, being around pets, and spending time outside.</p> <p>Review of resident 3's 8/29/14 annual summary activity progress note revealed "See attendance log in MR [medical record]. Not able to participate in group activities. Staff keep TV on in room. Family visits occasionally."</p> <p>Review of resident 3's 11/24/14 quarterly summary activity progress note revealed "Not able to participate in any group activities. Staff continue to keep TV on in room, and places him in dining room to watch as well. During meals</p>	F 248	<p>unable to attend activities for health or cognitive reasons.</p> <p>Audits will include that the care plan reflects activity participation and need for 1:1 structured activities with supportive documentation. The activity coordinator is responsible for audits to be completed for four residents per week X 1 month, then four residents monthly X 3 months and report the audit findings monthly to the QAPI committee for review and further recommendations.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2015
FORM APPROVED
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F 248	<p>Continued From page 5</p> <p>staff visits with him occasionally. Will continue to encourage staff to keep visiting with him and to try to start bringing out for music. Continue to monitor. No concerns with resident at this time."</p> <p>Review of resident 3's activity logs revealed: *For August 2014 - no documentation to support he had attended any activities for the month. *For September 2014 - no activity log had been located. *For October 2014: -He had watched TV in his room ten out of thirty-one days. -He had watched TV in the dining room seven out of thirty-one days. -No documentation to support any other type of one-on-one activity had been attempted during the month. *For November 2014: -He had taken a nap two times in one out of thirty days. -He had watched a video on Norway one out of thirty days. -No documentation to support any other type of activity or one-on-one visits had occurred for the month. *For December 2014: -He had watched TV in his room or the dining room nineteen out of thirty-one days. -He had taken a nap seventeen out of thirty-one days. -He had attended special music and the resident Christmas party on one out of thirty-one days. -He had not received any one-on-one visits from activities, nursing, or social services.</p> <p>Review of resident 3's 6/4/14 through 11/19/14 social service progress notes revealed on 6/4/14, 8/27/14, and 11/19/14 the social worker (SW) had</p>	F 248		
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F 248	<p>Continued From page 6</p> <p>visited one-on-one with him. There was no documentation to support any other one-on-one visits by the SW had occurred.</p> <p>Interview on 2/10/15 at 1:50 p.m. with the SW confirmed they had not been consistently doing any one-on-one visits with resident 3. She had recently visited with the activity director regarding the need to review all of their one-on-one programs.</p> <p>Surveyor: 29354</p> <p>2. Observation from 2/3/15 through 2/4/15 of resident 6 revealed she:</p> <ul style="list-style-type: none"> *Came out of her room for meals. *Spent the remainder of the time in her room. <p>Review of resident 6's medical record revealed:</p> <ul style="list-style-type: none"> *A 11/19/14 admission date. *The 11/19/14 activity assessment revealed she liked to sew, play board games, do crafts, go walking, watch TV, watch movies, play bingo, go on outings, draw, and put puzzles together. *A 11/19/14 temporary care plan had not addressed activities. *The activity attendance flow sheets from November 2014 through February 2015 revealed: <ul style="list-style-type: none"> -November 19-30, 2014 listed visitors, snack, card bingo once, music, and watched crafts once. -December 2014 listed devotions, snacks, church, visitors, nails, bingo, therapy, and Christmas party. -January 2014 listed snacks, visitor, therapy, devotions, nap, and nail care. -February 1-3, 2015 listed snack. *There was no other care plan for resident 6. <p>Interview on 2/3/15 at 3:20 p.m. with resident 6 revealed she spent most of the time in her room</p>	F 248		
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F 248	<p>Continued From page 7 and only came out for meals.</p> <p>Interview on 2/4/15 at 9:15 a.m. with the activities director (AD) regarding resident 6 revealed: *She came out for meals. *Staff provided one-to-one activities while giving her a snack. They would go into her room and offer a drink. They spent a few minutes with her. The certified nursing assistant would come in and finish assisting her with her drink or snack. *She tired easily and had not wanted to come out for scheduled out of room activities.</p> <p>Continued interview at the above time with the AD revealed: *She felt resident 6 could be isolated but when she asked her if she was all right she had replied yes. *She was not aware of the care plan. The director of nursing took care of the care plan. *She completed her section on the MDS assessment and then gave it to the MDS coordinator. *She had not attended care conferences. *There were no goals or objectives set-up for resident 6. *Her personal goal for resident 6 was to have her come out of her room more and socialize. She had not documented that anywhere. *She agreed resident 6 needed more activities. *She was employed forty hours per week. *There were other staff who assisted with activities with a total of thirty hours Monday - Friday and four hours on Saturday and Sunday every week. *The additional staff would have had time to spend with resident 6.</p> <p>Review of the provider's undated One-to-One</p>	F 248		

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F 248	Continued From page 8 Program policy revealed: **"A one-to-one programming will be established and utilized with all residents who will not, or cannot, effectively plan their own activity pursuits, or residents needing specialized or extended programs to enhance their overall daily routine and activity pursuit needs, as identified in the Activity Assessment." **"Identify the need for one-to-one programming by assessment in coordination with each MDS review example: isolation, refuse facility group activities." **"Document/chart each One-to-one contact with each resident on the activity log. Include date, time spent, and type of activity related to the focus of the program. Initial or sign each entry." **"The resident's comprehensive assessment, care plan, activity progress notes, and activity attendance records shall identify individual resident history, needs, interest and capabilities, degree of participation, and outcomes/responses to activity interventions." Review of the provider's undated Activity Program policy revealed the provider "shall provide for an ongoing program of activities/therapeutic recreation designed to meet the interests and the physical, mental, and psychosocial well-being of each resident."	F 248			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced	F 253	F253 Proper housekeeping and maintenance services should be done at all times. All residents are potentially at risk for safety violations. The maintenance supervisor will maintain	3/13/2015	

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F 253	<p>Continued From page 9</p> <p>by: Surveyor: 32355</p> <p>Based on random observation, interview, policy review, and job description review, the provider failed to ensure:</p> <ul style="list-style-type: none"> *Multiple wooden doors throughout the facility including residents' room doors had cleanable and safe surfaces. *Ceiling vents were clean and free of lint build-up in multiple resident bathrooms, three of three hallways (east, west, and north/south), and one of one bathing room. *The floor in one of one bathing room was free from stains and a black discoloration. <p>Findings include:</p> <p>1. Random observation from 2/3/15 through 2/4/15 of the facility revealed:</p> <ul style="list-style-type: none"> *Multiple brown wooden doors including residents' room doors throughout the facility had missing pieces of wood. Those missing pieces of wood left the surfaces exposed, uncleanable, and jagged. *The ceiling vents in multiple residents' bathrooms, in all three hallways, and in the bathing room were heavily soiled with built-up lint. *The grout in-between the tiles in the bathing room was discolored in several areas. The discoloration was black in color and gave the appearance of mold. <p>Interview on 2/5/15 from 9:00 a.m. through 9:15 a.m. during an environmental walk-through with the maintenance supervisor, administrator, director of nursing, and the infection control nurse revealed:</p> <ul style="list-style-type: none"> *They had not been aware of all the areas of concern. *They confirmed the wooden doors needed repair 	F 253	<p>equipment in such a manner to ensure safety and a positive homelike environment. The facility maintenance supervisor will complete written audits a minimum of 1 time per week X 4 weeks, then monthly X 3 months on wooden doors throughout the facility including residents' room doors to ensure they are cleanable and safe surfaces. The maintenance supervisor with the assistance of housekeeping personnel will clean inside of all ceiling vents by 5/31/15. The maintenance supervisor will then clean the inside of all vents twice per year and document completion in the maintenance record book. The facility housekeeping supervisor will complete written audits a minimum of 1 time per week X 4 weeks, then monthly X 3 months on cleaning the outside of all ceiling vents throughout the facility. The facility housekeeping supervisor will complete written audits a minimum of 1 time per week X 4 weeks, then monthly X 3 months on cleaning the grout in between the tiles in the tub room.</p>	
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F 253	<p>Continued From page 10 and were unsafe for those residents who were able to walk on their own. *The housekeeping department was responsible for the cleaning of the ceiling vents. The maintenance supervisor would have expected them to only clean the outside of the vents. Nobody had been designated to clean the inside of the ceiling vents. There was no maintenance preventative program in place for cleaning of the ceiling vents. *They could not confirm if the discoloration of the tiles was mold or not.</p> <p>Review of the provider's undated Housekeeping and Maintenance Department Responsibilities policy revealed "It is important to maintain a clean, safe, and sanitary environment for our residents. This is accomplished by rigorous daily cleaning of all horizontal surfaces in the building (tabletops, floors, counters, refrigerators, etc.) and by weekly cleaning of problem areas such radiators, cabinets, furniture, etc."</p> <p>Review of the provider's undated Director of Maintenance job description revealed: *"The primary purpose of your job position is to plan, organize, develop, and direct the overall operation of the maintenance department in accordance with current federal, state and local standards, guidelines, and regulations governing our facility, and as may be directed by the administrator, to assure that our facility is maintained in a safe and comfortable manner." *"Plan, develop, organize, implement, evaluate, and direct the maintenance department, its programs and activities." *"Assist in establishing a preventive maintenance program." *"Keep abreast of economic conditions/situations</p>	F 253	Results of the reviews will be reported to the administrator who will report any identified concerns to the QAPI committee that meets each month until the QAPI committee advises to discontinue.	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2015
NAME OF PROVIDER OR SUPPLIER STRAND-KJORSVIG COMMUNITY REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261		
(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 253	Continued From page 11 and recommend to the administrator adjustments in maintenance services that assure the continued ability to provide a clean, safe and comfortable environment."	F 253			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on record review, interview, and policy review, the provider failed to ensure one of nine sampled residents (6) had an updated comprehensive care plan with individualized and measurable goals, approaches, and interventions. Findings include:	F 279	F279 Failure to have a complete, comprehensive plan of care for resident #6: A comprehensive care plan for resident #6 was completed on 2/3/15 and has been updated on 2/8/15 and 2/18/15. All care plans were reviewed and updated by 2/8/15. Education on the care planning process was completed on 3/5/15 with the social service director, activity director, dietary manager, restorative director and MDS coordinator. Education on the care plans was completed on 3/4/15 at the all staff inservice, as well as through the nursing memorandum distributed to all licensed nurses on 3/5/15. For the initial care plan, each department manager will be responsible to complete their sections of the care plan by the day of the initial care conference on the blank care plan document. The care plan will then be entered into the computer	3/13/2015	

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F 279	Continued From page 12 1. Review of resident 6's medical record revealed: *An admission date of 11/19/14. *Diagnoses of right hip fracture, anemia (low iron), and underweight. *The nursing admission assessment identified she had skin issues and was at risk for developing a pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin). *She had a 11/19/14 temporary care plan. *There was no further care plan available for her. Interview on 2/3/15 at 4:00 p.m. with the director of nursing (DON) regarding resident 6 revealed: *The only care plan available for the resident was the 11/19/14 temporary care plan. *She was responsible for the care plans. *She had not had time to complete a care plan for the resident due "to working on the floor a lot over the past three months." *She confirmed the resident needed an updated care plan. Interview on 2/4/15 at 4:30 p.m. with the DON, Minimum Data Set (MDS) assessment registered nurse (RN), and the administrator revealed: *The DON was responsible for developing the care plans. *The MDS RN reviewed the care plans during each resident's care conferences. Care plans would be updated during that time. *The DON was responsible for the quarterly updates of the care plans. *Agreed resident 6 needed an updated care plan. Review of the provider's November 2011 Temporary Care Plan policy revealed:	F 279	within one week by the DON or MDS coordinator. Any care planning concerns or difficulty with completion will be brought to the QAPI committee monthly for review and further recommendations. <i>* Audits of new admissions for completion of initial care plans will be done by the DON or designee weekly times 4 weeks and then report to QAPI committee for further recommendation.</i>	
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F 279	Continued From page 13 *"The purpose was to provide information on a new resident so staff are informed of care needs prior to the care conference." *"The Temporary Care Plan is only in use until the complete care plan is finished or the condition that caused the change is resolved and that resident has returned to baseline." Review of the provider's undated Care Plan: Resident Assessment As Basis for Comprehensive Care Plan policy revealed: *"A designated Registered Nurse will coordinate a comprehensive resident assessment within 7 days of each admission. The resident's comprehensive care plan will be developed based on this assessment. *Each resident will be examined on a quarterly basis. Necessary revisions of the care plan will take place with each review."	F 279			
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	F 280	<i>*including residents 1,2,3,5,7 and 9</i> F280 Updating the comprehensive care plan: Failure to update the plan of care at least quarterly and upon any additional changes in the resident plan of care PRN: All care plans were reviewed and updated by 2/8/15 and any changes that have occurred with any residents since then have been updated on their care plan. Education on the care planning process was completed 3/5/15 with the social service director, activity director, dietary manager,	3/13/2015	

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F 280	<p>Continued From page 14 and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35120 Preceptor: 29354 Based on record review, interview, and policy review, the provider failed to review and revise as needed at time of quarterly assessment or significant change care plans for six of nine sampled residents (1, 2, 3, 5, 7, and 9). Findings include:</p> <p>1. Review of resident 1's medical record revealed: *She had diagnoses of osteoarthritis (disease of the joints, involves pain and stiffness of affected joints), hypertension (high blood pressure), diabetes type 2 (chronic condition that affects the way the body processes blood sugar), anxiety, depression, vitamin D deficiency (low vitamin D), and vascular dementia (gradual loss of mental function). *Her 1/10/15 Minimum Data Set (MDS) assessment revealed she: -Had a Brief Interview for Mental Status (BIMS) (memory test) score of five (indicates severe cognitive [mental] impairment). -Needed assistance moving in bed. -Was frequently incontinent (unable to control bladder). -Occasionally had pain. -Was at risk to develop pressure ulcers. -Had one unstageable (tissue loss in which the actual depth is unable to be seen) pressure ulcer.</p>	F 280	<p>restorative director, and MDS coordinator. Education on the care plans and the requirement to update them in a timely matter, as changes occur, was completed on 3/4/15 to all staff at the inservice training, as well as through the nurses' memorandum distributed to all licensed nurses on 3/5/15. Any care planning concerns or difficulty with completion will be reported to the QAPI committee monthly for review and further recommendations.</p>	
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F 280	<p>Continued From page 15</p> <p>-Had one fall since the last MDS assessment had been completed.</p> <p>*Her most current Braden scale (predicts risk of developing a pressure ulcer) on 11/21/14 was 18. -A total score of 12 or less represents a high risk of developing a pressure ulcer.</p> <p>*Her 11/21/14 fall risk evaluation had a score of 20 representing a high risk for falls.</p> <p>Review of resident 1's physician's orders revealed on:</p> <p>*11/21/14 she was to have her TED hose (compression stocking) on in the morning and taken off each night for six weeks after surgery.</p> <p>*1/29/15 she had Tylenol and Hydrocodone ordered for pain as needed (PRN).</p> <p>Review of resident 1's 7/10/14 care plan revealed:</p> <p>*No documentation of current medical issues and interventions for her.</p> <p>*She had not been taking medication for pain.</p> <p>*She was to have TED hose on in the morning and taken off at night.</p> <p>Interview on 2/4/15 at 3:42 p.m. with the director of nursing (DON) regarding resident 1 revealed:</p> <p>*The date of 7/10/14 on her care plan was the last time it had been reviewed and revised.</p> <p>*Her care plan should have reflected the changes in her condition.</p> <p>*Her TED hose had been discontinued by the physician.</p> <p>2. Review of resident 9's medical record revealed:</p> <p>*She had diagnoses of type 2 diabetes, reactive confusion (emotional state with unclear thinking), depression, macular degeneration (loss of</p>	F 280		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 16</p> <p>vision), hypertension, and osteoporosis (a condition in which the bones become weak and brittle).</p> <p>*Her 11/27/14 MDS assessment revealed she:</p> <ul style="list-style-type: none"> -Had a BIMS score of 15 (no cognitive impairment). -Needed assistance of one staff member to help her with walking, dressing, and bathing. -Was always continent of bowel and bladder. -Had no pain, falls, or pressure ulcers. -Was not high a risk for falls or to develop pressure ulcers. <p>Review of resident 9's 10/24/13 care plan revealed she:</p> <ul style="list-style-type: none"> *Was to have her circulation (blood flow to hands and feet) checked every four hours and PRN. *Could only bear fifty percent of her weight on her right leg. *Had a circulating air mattress on her bed. <p>Interview on 2/4/15 at 3:42 p.m. with the DON regarding resident 9 revealed:</p> <ul style="list-style-type: none"> *Her care plan had last been reviewed and revised on 6/17/14. *All care plans should have been updated quarterly (every three months) and PRN. <p>Surveyor: 18560</p> <p>3. Review of resident 2's 7/10/14 care plan revealed she shared a queen bed with her husband and did not have side rails on her bed.</p> <p>Random observation from 2/3/15 through 2/5/15 and from 2/10/15 through 2/11/15 of resident 2's room revealed two single beds not one queen bed. Resident 2's bed had side rail assist bars on both sides at the top of her bed.</p>	F 280		
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F 280	<p>Continued From page 17</p> <p>Surveyor: 32355</p> <p>4. Review of resident 3's complete medical record revealed:</p> <ul style="list-style-type: none"> *An admission date of 11/30/11. *Diagnoses of dementia (forgetfulness) with behavioral disturbances, history of respiratory (lung) infections, bilateral (both) inguinal scrotal hernia (soft tissue protruding through the muscle), dysphasia (swallowing difficulties), and glaucoma (poor vision). *He had been diagnosed with a respiratory infection on 1/15/15. *On 1/15/15 the physician had given the following orders: <ul style="list-style-type: none"> -Levaquin (antibiotic) 750 milligrams (mg) daily by intravenous (IV) for seven days. -Clindamycin (antibiotic) 300 mg to be administered every 12 hours by IV for five days. -Albuterol (increases airflow in the lungs) solution to be administered four times a day and as needed (PRN). -Oxygen 1 to 3 liters per nasal cannula PRN to keep oxygen levels in the blood greater than or equal to 90% (percent). -Oral suctioning (removes increased secretions from the mouth) PRN. *On 1/19/15 the physician had written an order placing the resident on comfort care (end-of-life). <p>Review of resident 3's 9/2/14 care plan revealed:</p> <ul style="list-style-type: none"> *No date indicating his care plan had been reviewed and revised after 9/2/14. *On 2/3/15 at 2:00 p.m. this surveyor requested a photo-copy of the 9/2/14 currently in-use care plan from the DON. *This surveyor observed the DON make the 	F 280		
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F 280	<p>Continued From page 18</p> <p>following corrections to this care plan prior to making a photo-copy. Those changes had been:</p> <ul style="list-style-type: none"> -A problem area stated "Comfort cares d/t (due to) decrease in swallowing difficulties and advanced dementia." -A goal stated "Resident will not aspirate during next 90 days." -Discontinuing an approach of "May alter delivery of meds (medications) according to resident needs or wishes." She had written beside the approach "D/C (discontinue) comfort cares no oral meds." <p>*Those above changes made by the DON had not been observed on his care plan prior to the photo-copy made for this surveyor.</p> <p>*There was no documentation of his:</p> <ul style="list-style-type: none"> -Change in condition on 1/15/15. -Swallowing difficulties and the need to be suctioned PRN. -Respiratory infection and the need for IV antibiotics, oxygen, and albuterol treatments PRN. <p>5. Review of resident 5's current care plan revealed it had not been reviewed or revised since 10/21/14. There had been no documentation to support his care plan had been reviewed with his most recent MDS assessment on 1/15/15.</p> <p>6. Review of resident 7's current care plan revealed it had not been reviewed or revised since 7/22/14. There had been no documentation to support her care plan had been reviewed with her most recent MDS assessment on 1/1/15.</p> <p>7. Interview on 2/4/15 at 11:00 a.m. with the MDS assessment coordinator revealed she had been responsible for the MDS assessments. She had</p>	F 280		
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F 280	<p>Continued From page 19</p> <p>not been responsible for the reviewing and revising of the care plans with those assessments. The DON would have reviewed and revised the care plans.</p> <p>Interview on 2/4/15 at 11:30 a.m. with the DON confirmed:</p> <ul style="list-style-type: none"> *The residents' care plans had not been reviewed and revised on a regular basis. *She had been responsible for the reviewing and revising of all the residents' care plans. *They had been short on staff since last fall. *She had been working on the floor weekly. *She had not had the time required to update the care plans since she had been working the floor. *All care plans should have been updated quarterly and PRN. <p>Interview on 2/4/15 at 4:30 p.m. with the administrator, DON, and MDS coordinator revealed:</p> <ul style="list-style-type: none"> *The DON had been responsible for most of the care plans. She would have updated them quarterly. *The care plans had been reviewed during the residents' care conferences. The DON would have made the necessary changes to the care plans at that time. *They further confirmed the DON had been working on the floor since this past fall. Since she had been working on the floor the care plans had not been updated timely. <p>Review of the provider's undated Care Plan/Comprehensive Interdisciplinary policy revealed:</p> <ul style="list-style-type: none"> *Policy "A comprehensive care plan will be developed for each resident CAA (comprehensive area assessment) completion date plus seven 	F 280		

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F 280	Continued From page 20 calendar days. The care plan must include measurable objectives and timetables to meet a resident's medical, nursing, and psychosocial needs as identified in the comprehensive assessment." *Procedure: -"The interdisciplinary team shall develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment." -"The interdisciplinary team may include the DON, MDS coordinator, registered nurse responsible for resident's care, resident, resident's family or legal representative, dietitian or dietary manager, social services designee, activities coordinator, and other appropriate staff."	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, record review, interview, and policy review, the provider failed to ensure: *Professional standards for initialing of medications prior to administration and not timely after administration for one of one medication aide (B) and one of two licensed nurses (A) observed during medication (med) administration. *Medications were administered by the nurse or medication aide who had set-up the medication for one of one resident (5). *Proper administration of a nebulizer treatment	F 281	F281 Failure to follow professional standards for medication administration, properly written orders, implementing orders or discontinuance of orders: Nursing memorandum was created by DON on 3/3/15, which included information on professional standards for nursing. A memorandum was also created for medication aides (UAPs) to include information on professional standards for proper medication administration. These memorandums were distributed to all licensed nurses and UAPs on	3/13/2015

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F 281	<p>Continued From page 21</p> <p>for one of one sampled resident (12). *A self-administration assessment had been completed for one of one sampled resident (12) who self-administered nebulizer treatments. *Clarification of physician's orders for one of one resident (15) observed who received eye drop medication, for one of one sampled resident (1) observed with TED hose (compression stockings), and for standing orders for all residents. Findings include:</p> <p>1a. Observation and interview during the med pass on 2/3/15 with licensed practical nurse (LPN) (A) revealed: *From 10:25 a.m. through 11:20 a.m. she initialed residents 11 and 15's Medication Administration Records (MAR)s before setting up their oral meds. *At 11:20 a.m. without performing hand hygiene she: -Drew up 16 units of Humalog insulin for resident 11. -Marked "16" on the MAR as the amount of insulin given. -Administered the insulin to resident 11. -Had not initialed the MAR after she had given the insulin. -Confirmed she had not signed the MAR after the insulin had been administered.</p> <p>b. Observation and interview on 2/3/15 at 11:30 a.m. of LPN A revealed she: *Was observed initialing different residents' MARs. *Confirmed she was signing MARs of meds she had administered at breakfast. *Should have initialed the meds on the MARs when the meds had been given.</p>	F 281	<p>3/5/15. They must sign and return the agreement to the DON by 3/13/15 that they will follow all professional standards. The nursing memorandum includes information on proper medication administration and documentation of administration, professional standards for writing up a physician's order, how to monitor for those medications that have been discontinued, and to ensure the orders are implemented as directed. The 'medication administration evaluation' completed by the pharmacist quarterly will be used to evaluate the nurses medication pass by the DON. A medication pass evaluation will be done weekly or more often of varying nurses and UAPs until all are assessed. Follow up and additional training will be addressed at that time if additional education is found to be necessary. Varying nurses/UAPs will be assessed weekly until consistent correct medication passes are observed, then monthly. Any concerns regarding the administration of medications will be addressed by</p>	
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F 281	<p>Continued From page 22</p> <p>c. Observation and interview on 2/3/15 of medication aide (MA) B revealed: *At 11:49 a.m. she: -Was observed initialing different residents' MARs. -Confirmed she was signing MARs of meds she had administered at breakfast. -Should have initialed the meds on the MARs when the meds had been given. *From 11:51 a.m. through 12:02 p.m. she initialed residents 4, 5, 16, and 17's MARs before setting up their meds.</p> <p>d. Observation and interview on 2/3/15 of LPN A revealed: *At 12:00 noon she: -Signed off resident 13's meds on the MAR before she administered them. -Set the cup of pills on resident 13's table and walked away. -Stated resident 13 would take them after she was done eating. -Left the pills at the resident's table as she liked to take her meds when she wanted to take them. *At 12:07 p.m. she signed off resident 14's Digoxin (heart med) before she administered it to him. *At 5:18 p.m. she signed off resident 13's Ranitidine (reflux/heartburn med) before administering it to her. *At 5:32 p.m. she had to write down resident 11's blood sugar and insulin from 12:00 noon as she had not recorded it at the time of testing and administration.</p> <p>2. Observation on 2/3/15 at 11:51 a.m. with MA B revealed: *She initialed the MAR for resident 5.</p>	F 281	<p>the QAPI committee and changes made accordingly. Regarding properly written orders and the implementation of orders, the nurses complete a physician's orders checklist when taking off orders. Changes have been implemented to this form to make sure the five rights are included in the order to make sure all orders are written and implemented properly. This is to be done with each order. DON will complete random reviews of new admission and hospital returns, as well as completing random review of orders. Any problems that are noted will be brought to the QAPI committee and addressed at that time. Regarding self-administration of medications: A new policy and assessment has been adopted by the facility to address those residents capable of administering their own medications once set-up is completed by the licensed nurse or UAP. Orders have been obtained by the physicians and are included in revised "Standing Orders". Those deemed appropriate by the assessment completion, may take their</p>	
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F 281	<p>Continued From page 23</p> <p>*She then:</p> <ul style="list-style-type: none"> -Placed resident 5's meds into a med cup. -Gave resident 5 the meds. Resident 5 refused the Baclofen (used for nerve pain) med. -Returned to the med cart, wrote the resident's name on the med cup, and placed the med cup with the pill inside the top drawer of the med cart. -Stated she would try to give the med to the resident after he had finished eating. <p>Observation and interview on 2/3/15 at 1:55 p.m. with LPN A revealed:</p> <ul style="list-style-type: none"> *The above med cup was not in the top drawer of the med cart. *She confirmed: -She had given the med to resident 5. -She had not initialed the MAR as having administered the med. -MA B had initialed the MAR as having administered the med. -MA B should not have initialed the MAR. -When the MAR was initialed it indicated the med had been given. <p>3. Interview on 2/4/15 at 3:42 p.m. with the director of nursing (DON) revealed she:</p> <ul style="list-style-type: none"> *Had not had an opportunity to observe LPN A passing meds as she had just started working at the facility a few weeks ago. *Would have expected LPN A to administer the meds before signing them off on the MAR. <p>Continued interview on 2/10/15 at 1:45 p.m. with the DON confirmed:</p> <ul style="list-style-type: none"> *The nurses were to initial off the MAR when administering insulin not just record the amount of units of insulin administered. *The MARs should have been initialed after the meds had been administered. 	F 281	<p>medications at their leisure at the table or in their room and may be left unattended during nebulization therapy after set up. This assessment will be completed by the DON or other designated licensed nurse upon admission and quarterly, as well as with any significant changes. Any concerns or changes will be brought to the QAPI committee for review monthly for four months.</p>	
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F 281	<p>Continued From page 24</p> <p>*The nurse or medication aide setting up the meds should have been the one administering the meds.</p> <p>Review of the South Dakota Board of Nursing statement dated 10/17/06 revealed "It is the position of the South Dakota board of Nursing that the standard for safe administration of medications includes the practice of documenting medication following administration to the patient."</p> <p>4. Observation on 2/3/15 revealed: *At 4:20 p.m. LPN A: -Took a Duoneb (med used for the lungs) cartridge from the med cart. -Went into resident 12's room and placed the med in the holder of the nebulizer. -Placed the mask on resident 12 and turned the nebulizer machine on. -Told resident 12 she would be back in ten minutes. -Left the room. *At 4:30 p.m. and 4:50 p.m. resident 12 had the nebulizer mask on and the nebulizer machine on. *At 4:53 p.m. resident 12 still had the nebulizer mask on and the machine running. The nebulizer had been on for thirty-three minutes. *At 4:55 p.m. certified nursing assistant (CNA) D entered resident 12's room. She then: -Took the mask off of resident 12. -Without rinsing the mask laid the mask on the dresser. -Confirmed she was not a medication aide. -Confirmed she had not rinsed the nebulizer mask off after removing it from resident 12.</p> <p>Review of resident 12's medical record revealed: *There was no physician's order to</p>	F 281		
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F 281	<p>Continued From page 25</p> <p>self-administer the nebulizer treatment. *There had been no assessment form completed for the resident to self-administer medication.</p> <p>Interview on 2/10/15 at 1:45 p.m. with the DON regarding resident 12 confirmed: *They had never obtained physician's orders for residents to self-administer nebulizer treatments. *She had never considered leaving a resident alone with a nebulizer treatment as self-administration of a med. *The nurses usually came back to the residents' rooms to check on them during the administration of a nebulizer treatment. *CNA D should not have removed the nebulizer mask.</p> <p>Review of the provider's undated Self-Administration of Medications policy revealed: **The Competence to Self-Administer Medication Form will be utilized to determine a resident's competency every three months. *A physician order must also be obtained for a resident to self-administer medications. *The order must contain specific list of medications the resident is requesting and a signed Doctor order for those medications."</p> <p>5. Observation and interview on 2/3/15 at 10:25 a.m. of LPN A revealed she: *Took a bottle of Gen Teal eye drops from the med cart. *Went into resident 15's room and administered the eye drops into both of the resident's eyes.</p> <p>Interview at the above time with LPN A revealed: *She had placed one drop into each of resident 15's eyes.</p>	F 281		
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F 281	<p>Continued From page 26</p> <p>*The physician's order on the MAR had not specified how many drops or which eye to place the eye drops into.</p> <p>Interview and observation on 2/4/15 at 10:30 a.m. with LPN G regarding resident 15 revealed: *The MAR had not specified how many drops or which eye to place the eye drops into. *They usually used the orders on the eye drop box. *She then took the Gen Teal eye drop box and peeled the pharmacy label back. The box recommendations were to use one to two drops in the affected eye.</p> <p>Interview on 2/10/15 at 1:45 p.m. with the DON confirmed the amount of eye drops and which eye to administer the drops in should have been specified.</p> <p>Review of the provider's October 2007 Eye Drop Medication Administration policy revealed to administer ophthalmic (eye) solution into eye in a safe and accurate manner.</p> <p>Surveyor: 35120 Preceptor: 29354</p> <p>6. Observation on 2/3/15 of resident 1 revealed: *At 10:15 a.m. she was sitting in her recliner with her feet elevated and had her TED hose on both legs. *LPN A removed her TED hose before doing her dressing change. *The TED hose were reapplied after the dressing change.</p> <p>Review of resident 1's medical record revealed: *7/10/14 care plan stated she had TED hose put on in the morning and removed at night.</p>	F 281		
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F 281	<p>Continued From page 27</p> <p>*Physician's orders on: -11/21/14 stated she was to wear the TED hose for six weeks post-op (after surgery). -1/29/15 showed no order or re-ordering for the resident to continue the TED hose.</p> <p>Interview on 2/4/15 at 4:25 p.m. with the DON regarding resident 1 revealed: *The TED hose should have been discontinued six weeks post-op. *There had not been a new order from the wound care specialist to continue the use of resident 1's TED hose.</p> <p>7. Review of resident 1's medical record revealed she had a: *Standing order (S.O.) for Mucinex (cold medication) 600 milligrams (mg) twice a day (BID) as needed (PRN) for cold symptoms on her MAR. *Physician's orders dated 1/29/15 for S.O. Mucinex 600 mg BID PRN for cold symptoms and an order to use S.O.s as indicated. *No medication route (how to take the medication) had been documented.</p> <p>Review of the provider's 5/7/13 Physician's Standing Orders revealed there were multiple medications listed without a route or a dosage (amount of medication to be taken).</p> <p>Interview on 2/4/15 at 3:42 p.m. with the DON revealed she thought if an order had not specified a route then it was always given by mouth.</p> <p>Review of the provider's undated Physician Orders policy revealed "Each medication order must have a route, dose, frequency and related diagnosis."</p>	F 281		
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F 281	<p>Continued From page 28</p> <p>8. Review of the provider's undated Medication Administration General Guidelines policy revealed: "Medications are administered as prescribed in accordance with manufactures' specifications, good nursing principles and practices and only by persons legally authorized to do so.</p> <p>*Medications are administered at the time they are prepared.</p> <p>*The person who prepared the dose for administration is the person who administers the dose.</p> <p>*Residents are allowed to self-administer medications when specifically authorized by the prescriber, the nursing care center's Interdisciplinary Team (IDT) and in accordance with procedures for self-administration of medications and state regulations.</p> <p>*The resident is always observed after administration to ensure that the dose was completely ingested.</p> <p>*The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications.</p> <p>*The resident's MAR/TAR (treatment sheet) is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration and time.</p> <p>*Once removed from the package/container, unused medication doses shall be disposed of according to the nursing care center policy."</p>	F 281		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=G	<p>Continued From page 29 HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure effective pain management for: *One of one sampled resident (3) who was cognitively (memory) impaired with communication deficits and on comfort care (end-of-life). *One of one sampled resident (1) during a dressing change by one of one licensed practical nurses (LPN) (A). Findings include:</p> <p>1. Review of resident 3's complete medical record revealed: *An admission date of 11/30/11. *Diagnoses of dementia (forgetfulness) with behavioral disturbances, dysphagia (swallowing difficulties), bilateral (both) inguinal hernia (soft tissue protruding through muscle) of the scrotum, respiratory (lung) infections, abnormal body movements, and glaucoma (poor vision). *He was not interviewable. *The staff had to anticipate his needs due to his communication deficit. *He had been dependent upon staff to meet all of</p>	F 309	<p>F309 <u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u> Residents #1 and #3 were reassessed for pain on 3-2-15. Both residents' physician reviewed the resident's need for any pain management/treatment on 3-2-15. All residents have been assessed for pain according to their MDS schedule. For those residents that have cognitive impairment, the MDS pain assessment will be completed more than once during their assessment period to get a more accurate overview of their needs as well as being assessed PRN. Assessing for pain and proper documentation of "the fifth vital sign" was addressed with all staff</p>	3/13/2015
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F 309	<p>Continued From page 30</p> <p>his activities of daily living needs.</p> <p>*On 1/15/15 he had acquired a respiratory (lung) infection with the following physician's orders:</p> <ul style="list-style-type: none"> -Levaquin (antibiotic) 750 milligrams (mg) daily by intravenous (IV) for seven days. -Clindamycin (antibiotic) 300 mg to be administered every 12 hours by IV for five days. -Albuterol (increases airflow in the lungs) solution to be administered four times a day and as needed (PRN). -Oxygen 1 to 3 liters per nasal cannula PRN to keep oxygen levels in the blood greater than or equal to 90% (percent). -Oral suctioning (removes increased secretions from the mouth) PRN. <p>*On 1/19/15 the physician had written an order placing the resident on comfort care.</p> <p>*His January 2015 Medication Administration Record listed eleven scheduled medications. One of those medications had been Tylenol (fever reducer and pain reliever) 650 mg orally twice a day.</p> <p>*He had been taking the scheduled Tylenol since 1/4/12.</p> <p>*On 1/19/15 he had been placed on comfort care with all of his oral medications discontinued including the Tylenol.</p> <p>*The physician had ordered Ativan (antianxiety) 0.5 to 1.0 mg intramuscular (an injection into the muscle) every four hours PRN.</p> <p>*No medications had been ordered for pain or discomfort.</p> <p>Review of resident 3's 11/20/14 Minimum Data Set (MDS) assessment revealed:</p> <ul style="list-style-type: none"> *He was hard of hearing and rarely understood others. *His vision was highly impaired. *He had not been able to be interviewed to 	F 309	<p>at the inservice training on 3/4/15 and also through the nurses memorandum of professional standards and changes they have to review, sign and return to DON by 3-13-15. Audits will take place with 4 chart reviews done weekly times 4 weeks and then will address with QAPI committee for further advice.</p>	
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F 309	<p>Continued From page 31</p> <p>establish his current memory recall. *He was unable to ambulate and required extensive assistance of two staff members for transfers and moving in bed.</p> <p>Review of resident 3's progress notes revealed: *On 1/15/15 he had a fever (elevated body temperature) ranging between 99.4 to 101.4 degrees Fahrenheit (F). He had not been swallowing effectively and required suctioning. The physician had been notified and the above orders were received. *On 1/16/15 he continued to have an elevated temperature. The nursing staff had provided PRN Tylenol to help reduce his fever. The physicians' assistant (PA) had been updated on his continued deteriorating condition. The PA had requested the staff visit with resident 3's spouse regarding comfort care. The wife was notified. *On 1/17/15 at 3:15 p.m. "No s/s [signs or symptoms] of pain noted. Remained in bed. Repositioned and hygiene care routine. Has accepted most care but does push staff away when not wanting to eat or accept neb [nebulizer] treatment. Increased restlessness at supper time." No documentation to support anything had been administered for his restlessness. *On 1/17/15 at 10:50 p.m. "Resident became extremely agitated when this nurse attempted to give neb treatment this evening. Began to holler loudly while pulling on nebulizer mask. Also striking out at staff with his fist. Respiratory congestion noted with occasional harsh cough. Restless at times." *On 1/18/15 with no time charted. The staff had discussed comfort care with his wife. She was going to consult with family at that time. "Resident remained in bed with repositioning and hygiene care." "Is easily agitated with cares - grabs out at</p>	F 309		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2015
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NAME OF PROVIDER OR SUPPLIER STRAND-KJORSVIG COMMUNITY REST HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261
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F 309	<p>Continued From page 32</p> <p>staff, eyes become wide open with starring look." Temperature to 99.9 degrees F with Tylenol suppository (given rectally) given for the elevated temperature.</p> <p>*On 1/18/15 at 11:40 p.m. "Resident becomes agitated when staff attempt cares. Yells out, swings his fists and attempts to strike out."</p> <p>*On 1/19/15 with no time charted. He had pulled out his IV during the night. PAC ordered the IV to be discontinued and to follow-up with the wife regarding comfort care.</p> <p>*On 1/19/15 at 7:30 p.m. The wife had been contacted, and the family had been agreeable with the orders for comfort care. "[Wife's name] also asked if we were going to initiate Hospice (support program for end-of-life)." "Shared that staff (supervisory) would evaluate and talk with her about opportunities."</p> <p>*On 1/19/15 and on 1/20/15 resident 3 had continually removed his O2 tubing.</p> <p>*There had been no documentation to support the:</p> <ul style="list-style-type: none"> -Ativan had been administered for his restlessness. -Nursing staff had administered the Tylenol as a pain reliever. <p>Observation on 2/3/15 at 10:45 a.m. with certified nursing assistants (CNA) (F and J) assisting resident 3 with personal care revealed:</p> <ul style="list-style-type: none"> *He was in his room. *He had been quietly sitting in his wheelchair (w/c). *He had required the use of a hanger mechanical lift (device to assist with transfers) to assist him with standing. *The CNAs: <ul style="list-style-type: none"> -Placed a Hoyer sling around him and fastened it to the mechanical lift. 	F 309		
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F 309	Continued From page 34 Interview on 2/4/15 at 11:00 a.m. with the MDS assessment coordinator revealed: *She had been responsible for the resident's pain assessments. *She had not used any formal type of form to complete a pain assessment. The nurses had a pain management assessment form to be used as a tool for them to determine a resident's pain level. *She would have only performed her required pain interview from the MDS section J. *She agreed that moaning, grimacing, stiffening, and clenching of fists were all signs of pain. She also considered those signs of anxiety. *Resident 3 had always exhibited those behaviors since he had been admitted in 2011. They had increased when he had a respiratory infection. *She knew his scheduled Tylenol had been discontinued on 1/19/15 with no further pain medications recommended. *She could not confirm the Tylenol twice a day had helped control any of those behaviors he had exhibited. *She could not provide documentation to support how they had determined those behaviors resident 3 exhibited were anxiety versus pain. *She further confirmed the provider had not administered any of the above ordered Ativan to resident 3 to determine if his behaviors were anxiety induced. *After his respiratory infection had resolved she had considered those behaviors normal for him. Interview on 2/4/15 at 11:30 a.m. with the director of nursing revealed she: *Supported the above interview with the MDS coordinator. *Had considered the staff to be proficient (doing a	F 309			

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F 309	<p>Continued From page 35</p> <p>good job) providing pain management. *Could not provide this surveyor with any documentation to support the supervisory staff had a follow-up conversation with resident 3's wife regarding hospice support and care. *Stated "It was just a phone call. The wife was comfortable with the care we are providing."</p> <p>Review of resident 3's 9/2/14 care plan revealed: *The following approaches: -"Assist resident with all decisions. Resident will indicate stress/pain by looking anxious, and moaning more. He does not communicate so all needs need to be anticipated." -"History of grabbing staff and other residents prior to admission." -"Need to anticipate his needs. Speak directly and close to him to get his attention. Only moans, if increase in moaning or restlessness, could be pain, try and figure out what he needs." -"Pain: Noted to have increase in restlessness and moaning in the morning and afternoon. Started Acetaminophen (Tylenol) 650 BID (twice a day) and this has improved. Will need to anticipate his needs and be mindful of possible pain if resident is restless or moaning more than usually." *A line had been drawn through the acetaminophen sentence with no discontinued date provided.</p> <p>Review of resident 3's monthly pharmacy consultation reports from April 2014 through January 2015 revealed: *No documentation to support: -The discontinuation of a pain medication that the resident had been taking for some time. -Or encourage another type of pain medication for comfort during the resident's end-of-life.</p>	F 309			

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F 309	<p>Continued From page 36</p> <p>*Under the comment section the word "none" had been written.</p> <p>*No further documentation was found to support the pharmacist had completed a thorough review of the resident's current health and medical condition.</p> <p>Interview on 2/10/15 at 12:45 p.m. with the consulting pharmacist revealed he:</p> <p>*Would not have reviewed a resident's chart for adequate pain management.</p> <p>*Stated "I feel doctors prescribe too many pain medications and the residents get addicted to them."</p> <p>Review of the provider's undated Pain Assessment and Management policy revealed:</p> <p>*Policy "It is the policy of [provider name] to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain."</p> <p>*General Guidelines "Conduct a comprehensive pain assessment upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain."</p> <p>***"The staff and physician will identify the nature and severity of pain."</p> <p>***"The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated; for example - wound care, ambulation, or repositioning."</p> <p>Review of the provider's undated Comfort Care policy revealed:</p> <p>*Policy "The goal of comfort care is to promote dignity of the resident and to minimize pain and/or discomfort."</p>	F 309		
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F 309	Continued From page 37 *Some of the provisions for comfort care had been: -"Pain management." -"No medications unless resident is willing and able to ingest." -"Medications will be discontinued at the physician's discretion." Surveyor: 35120 Preceptor: 29354 2. Observation on 2/3/15 from 4:10 p.m. through 4:20 p.m. revealed licensed practical nurse (LPN) A completed a dressing change to resident 1's right heel. At no time had LPN A asked resident 1 about her pain level. Interview with resident 1 immediately following LPN A's completing her dressing change revealed her pain level was 3 to 4 (on pain scale of 0 through 10 with 0 being no pain and 10 being the worst possible pain) while the dressing change was being completed. Further interview on 2/4/15 at 1:45 p.m. with resident 1 revealed staff never asked her if she wanted pain medicine before her dressing changes. Record review of resident 1's nurses notes dated 2/3/15 revealed LPN A documented resident 1 had "no complaints of pain."	F 309			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314	F314 <u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report.</u>	3/13/2015	

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F 314	<p>Continued From page 38</p> <p>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: 35120 Preceptor: 29354 Based on observation, interview, record review, and policy review, the provider failed to assess, identify, and implement interventions for residents at risk of developing pressure ulcers (injury to skin and underlying tissue resulting from prolonged pressure on the skin) for two of two sampled residents (1 and 6) resulting in two facility acquired pressure ulcers. Findings include:</p> <p>1. Review of resident 1's 1/10/15 Minimum Data Set (MDS) assessment revealed she: *Had been readmitted on 11/14/14 after hip surgery. *Had a Brief Interview for Mental Status (BIMS) (memory test) score of five which indicated severe cognitive impairment (a deterioration or loss of mental functioning). *Needed extensive assistance of two or more staff members for help with: -Bed mobility (moving/changing positions). -Transfers (moving from one spot to another). -Walking. -Dressing. -Toilet use. -Bathing. *Was frequently incontinent (unable to control bladder) of urine. *Had occasional pain. *Had a fall since her last assessment dated</p>	F 314	<p><u>Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></p> <p>For resident #1: Acquired an unstageable sore to the right heel with physician orders for betadine whirlpools on 12-22-14. Braden score of 18 determined mild risk for skin breakdown. As of this date the heel is stage 3 healing. Wound measurements have been done weekly and treatments documented. The facility will ensure if the resident has an open area that the skin condition documentation sheet be initiated upon discovery of the wound and weekly thereafter to determine measurements. The nurse will complete weekly assessments to document progression of the wound. The care plan will be updated to reflect wound management and interventions. The physician will be notified immediately to begin treatment.</p> <p>For resident #6: Acquired an unstageable sore to the coccyx. The resident had scheduled</p>	
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F 314	<p>Continued From page 39 11/21/14.</p> <p>*Had one unstageable (tissue loss/damage where the depth is unable to be seen) pressure ulcer. *Had a pressure reducing device for her chair and received pressure ulcer care.</p> <p>Review of resident 1's 7/10/14 care plan revealed she: *Was able to dress her upper body but needed extensive assistance from staff with dressing her lower body. *Was able to assist with her upper body personal care after set-up and needed limited assistance with her perineal care (cleaning of her private area). *Needed assistance of one staff member for bathing. *Toileted herself during the day. *Needed extensive assistance of one staff member for moving in bed. *Could transfer herself but needed reminders to use her walker. *Walked to all destinations with the use of her walker. *Was at risk for falls. *Was at risk for skin breakdown due to not cleaning herself well after using the restroom and obesity (overweight) with decreased mobility. *Had no interventions in place to prevent her from developing a pressure ulcer.</p> <p>Review of resident 1's medical record revealed: *She had surgery on 11/10/14 for a fractured hip. *On 12/22/14 the provider discovered bloody drainage from her right heel when her TED hose (compression stockings) had been removed. *She had a 1.8 centimeter (cm) by 3.0 cm black area on her right heel. *Her skin condition documentation sheet started</p>	F 314	<p>hydrogel dressing covered with foam dressing. The physician was notified of the sore. At this time, the coccyx sore is healed. The charge nurse completed weekly measurements and assessment of the wound progression. For all other potential residents: The licensed nurses must ensure the residents identified with low Braden score and at high risk for skin breakdown have interventions in place to reduce the risk of pressure ulcers. The skin condition documentation sheet will be initiated upon discovery of a wound. The physician will be notified immediately to begin treatment. The care plan will be updated to reflect interventions and pressure sore management to prevent further skin breakdown and resolve any current skin impairments. Inservice: Education of policy for pressure ulcer prevention, skin condition documentation sheet, interventions to reduce risk and assist in prevention of pressure sores, the documentation of treatment in the MAR, skin condition documentation sheet for</p>	

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F 314	<p>Continued From page 40 on 12/22/14 revealed: -The pressure ulcer was unstageable. -She was to have an anti-pressure boot on when not walking.</p> <p>Interview on 2/3/15 at 10:15 a.m. with resident 1 revealed she did not wear anything special on her feet for her pressure ulcer. She wore her blue slippers all day. Observation during the interview showed resident 1 had been wearing her blue slippers at that time.</p> <p>Interview on 2/4/15 at 3:42 p.m. with the director of nursing (DON) revealed: *Resident 1's pressure ulcer was discovered on 12/22/14 by the bath aide. *She believed the resident acquired the pressure ulcer when she was in the hospital. *Her care plan should have been updated to reflect the change in her condition.</p> <p>Surveyor: 29354 2. Review of resident 6's medical record revealed: *An admission date of 11/19/14. *Diagnoses of right hip fracture and iron deficiency anemia (low iron in the blood). *A 11/19/14 admission nursing assessment: -Identified two staples to the right hip surgical sight three staples to the surgical sight, 3.0 cm by 5.0 cm to the middle of the spine, and an area to the right posterior (behind) upper thigh. -She required two staff assistance with transfers. *An 11/27/14 nursing summary flow sheet revealed: -She was frequently incontinent of bladder and bowel. -There were pressure reducing devices for her chair and bed.</p>	F 314	<p>weekly measurements and nurse assessment to the progression of the wound, and timely physician orders for treatment was all addressed at the inservice on 3/4/15 for all staff and specifically through the nursing memorandum distributed on 3/5/15.</p> <p>Audits: The DON and MDS coordinator will be responsible that the audits be completed to monitor the weekly completion of the skin condition documentation sheet and assessment, that interventions such as turning and repositioning occur and are documented by the CNAs. Audits will include that the physician orders were obtained timely when notified of alteration in skin integrity and monitoring of the MAR for documentation. Audits will be completed by the DON or MDS coordinator weekly X 1 month and monthly X 3 months. The DON will be responsible to report audit findings monthly to the QAPI committee for review and further recommendation.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 41</p> <ul style="list-style-type: none"> -The open skin lesions section was marked "No." -The ulcers section was marked "No." -The ability to make decisions section was marked moderately impaired. -The 11/26/14 Braden scale (used to identify at risk for skin problems (with a score of 12 or lower representing high risk) score of 17. <p>Review of resident 6's nurses notes revealed on:</p> <ul style="list-style-type: none"> *11/19/14 "When giving cares found open area on R [right] upper inner thigh. Measures proxy [approximately] 3 cm by 2 cm also 3 small open areas on back of thigh." *11/19/14 "She also has a skin tear in the middle of her back." *11/24/14 "Has 2 small healing areas on bone prominence [spine] of back. Was charted as an abrasion [scraped area] but may have been a very small pressure ulcer as alluded too on transfer but now looks like a pinpoint dimple." *12/3/14 "Coccyx [tail bone] area red as is bony prominence of spine." *12/17/14 "Bony prominence of spine red, coccyx red." *12/24/14 "Along spine area reddish purple." *12/26/14 "Open area to coccyx bony prominence see skin condition doc [documentation] form." *12/30/14 "Continuing care to coccyx opening." *12/31/14 "Coccyx area tx [treatment] continues et [and] shows improvement - tissue granulating [new skin tissue] et [and] redness decreasing. Foam placed on bony prominence of spine D/T [due to] redness." <p>Review of resident 6's 12/30/14 physician's order revealed "consult with wound care speciality and follow recommendations for opening on coccyx: Hydrogel dressing [type of wound covering] - cover with foam pad, change everyday."</p>	F 314		
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F 314	<p>Continued From page 42</p> <p>Review of resident 6's 1/6/15 physician's progress notes had no documentation regarding skin breakdown.</p> <p>Review of resident 6's 11/19/14 Temporary Care Plan revealed documentation for: Skin problems? "Yes-spine, coccyx and Right hip incision." There had not been any further care plan for her regarding those issues.</p> <p>Review of resident 6's MDS assessments and Care Area Assessment (CAA) summary revealed: *11/26/14 - admission MDS: -She required extensive assistance of two staff with bed mobility, dressing, transfer, toilet use, and personal cares. -She was frequently incontinent of bowel and bladder. -She was at risk for developing a pressure ulcer. -The section for resident "has stage 1 [reddened area] or higher pressure ulcer" was marked "No." -The section for skin problem was marked "skin tear." -The section for skin/ulcer treatment: turn and reposition was marked "not checked." *11/28/14 - CAA summary triggered for activities of daily living, urinary incontinence, nutritional status, and pressure ulcer. *Documentation on the CAA revealed: -Urinary incontinence - "Currently shows no s/s [signs or symptoms] of a pressure ulcer. She does have a surgical incision on her right hip and skin tear on her back." -Pressure ulcer - "At risk for pressure ulcers d/t [due to] extensive assistance with bed mobility. Does not currently have a pressure ulcer." *12/17/14 - Thirty day MDS revealed: -She required extensive assistance of one staff</p>	F 314		
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F 314	<p>Continued From page 43</p> <p>person with bed mobility, toilet use, bathing, and personal hygiene.</p> <p>-She was frequently incontinent of bowel and bladder.</p> <p>-She was at risk for developing a pressure ulcer.</p> <p>-No had been marked for pressure ulcers.</p> <p>3. Interview on 2/4/15 at 10:40 a.m. with the DON regarding resident 6 revealed:</p> <p>*She confirmed the nursing summary had stated a pressure relieving device had been on resident 6's bed.</p> <p>*12/30/14 was the first time the physician had been notified of the pressure ulcer and had made recommendations.</p> <p>*The nursing staff had taken orders from the Standing Orders for skin treatment prior to notifying the physician on 12/30/14.</p> <p>*They had not used the skin documentation for stage one pressure ulcer, but had for unstageable and other pressure ulcers.</p> <p>*She agreed the reddened area over bony prominences could have been a stage one pressure ulcer.</p> <p>*She agreed there had been no documentation for a stage one pressure ulcer.</p> <p>*She confirmed there was no policy for use of the skin condition documentation form.</p> <p>Review of the provider's undated Pressure Ulcer Treatment policy revealed:</p> <p>***The purpose of this procedure is to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcer.</p> <p>*Review the resident's care plan to assess for any special needs of the resident.</p> <p>*The pressure ulcer treatment program should focus on the following strategies:</p> <p>-Assessing the resident and the pressure ulcers.</p>	F 314		
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F 314	Continued From page 44 -Managing tissue loads. -Pressure ulcer care. -Managing infection. -Education and quality improvement."	F 314			
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 18560 A. Based on observation, interview, record review, and policy review, the provider failed to ensure side rails had been assessed for safety and entrapment (getting caught in) risk for six of six sampled residents (1, 3, 5, 7, 8, and 9) reviewed and for seventeen randomly observed residents with Hil-Rom side rails. That failure created a situation of immediate jeopardy that had the potential for causing harm to all of the residents with Hil-Rom side rails. NOTICE: Notice of immediate jeopardy was given verbally to the administrator and director of nursing (DON) on 2/5/15 at 10:45 a.m. The administrator was asked for an immediate plan of correction (POC) to ensure residents were assessed for the safe use of side rails for positioning.	F 323	F323 <u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u> Side rail safety: On 2-5-15, all bottom rails were removed from beds. Measurements were taken on the side rails/assistive devices on the beds as well as the mattresses. New individual assessment for "bed rail/ assist bar evaluation" was obtained. This assessment was completed for each current resident. Based on the findings of this assessment, for the beds of residents that were assessed to not need an assistive device, the top outside rail was	3/13/2015	

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F 323	<p>Continued From page 45</p> <p>PLAN:</p> <p>"On 2/5/15 at 4:25 p.m. the administrator provided the surveyors with the written (POC). The written POC dated 2/5/15 at 4:25 p.m. was accepted by the surveyors at 4:30 p.m. That immediate POC included:</p> <ul style="list-style-type: none"> *Remove all bottom bed rails that have not been in use. *Take measurements on side rails/assistive devices on beds. Perform individual assessments for each resident based on their level of cognition [memory] and indication for use of assistive devices on beds. *Based on each resident assessment, the top rails will either be secured in the down position with a zip-tie strap or be removed. On the Hill-Rom beds, the rail may be left in the up position against the wall with bed brakes on so that the resident may utilize the bed controls, if the resident is assessed with the cognitive ability to use the controls. *Based on the individual assessment for those that have a need/desire for a top side rail as an assistive device, accommodations will be identified to ensure the assistive devices meet the safety needs of each resident. The accommodations which will be utilized are temporary covers on the bed rails and to fill in the gaps until permanent solution is obtained. *Staff education meeting held on 2/5/15 at approximately 12:00 pm to inform staff members of the immediate concern for residents and plan of correction to address safety concerns related to assistive devices. All staff will be advised of safety concerns. *Those residents at risk for falls will be further monitored and evaluated for additional interventions to prevent falls. *Copy of assessment forms and staff education 	F 323	<p>either secured in the down position with a zip-tie strap or removed. For those assessed to need or desire an assistive device, padding with a covering was created to attach to the side rail between the rail and mattress to ensure each resident's safety. This was created as a temporary solution. For all Hill-Rom beds, which have the bed control on the top side rails, the wall-side rail is allowed to be in the up position, against the wall with the bed brakes in the 'on' position in order for resident or staff to position the bed in the desired position. On 2-11-15, an order was placed with Direct Supply for 14 Panacea 1500 beds and mattresses of correct size. Beds arrived to the facility on 2-25-15. Mattresses are scheduled to arrive on 3-9-15. These beds and mattresses will then be immediately utilized for those residents identified with a need/desire for an assistive device to permanently replace the temporary adaptation created to address the immediate jeopardy on 2-5-15. The DON, MDS coordinator, or other designated</p>	
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F 323	<p>Continued From page 46 attached."</p> <p>During the survey on 2/5/15 at 4:30 p.m. the surveyors confirmed removal of the immediate jeopardy situation.</p> <p>Findings include:</p> <p>Surveyor: 29354</p> <p>1. Observation from 2/3/15 through 2/5/15 at 9:30 a.m. of resident 8's bed revealed: *Four Hil-Rom 1/2 side rails attached to the bed. *Two Hil-Rom 1/2 side rails were in the up position at the head of the bed.</p> <p>Review of resident 8's medical record revealed: *An admission date of 3/4/14. *Diagnoses of malaise (tired) and fatigue, dementia (confusion), and mild cognitive impairment. *Side rails to be used for repositioning. *The 3/4/14 physician's hospital discharge summary stated her principle problem was generalized weakness, inability to perform activities of daily living (ADLs), fecal incontinence, dementia (memory), and sundowning (confusion at night). *She had been admitted on psychotropic medications (mood altering). *The 2/3/15 physician's order stated to continue with side rails for repositioning.</p> <p>Review of resident 8's Minimum Data Set (MDS) assessment revealed: *3/11/14 admission MDS revealed: -The Brief Interview for Mental Status (BIMS) assessment was a three. Three indicated severe cognition (memory) impairment. -She required extensive assistance of two staff</p>	F 323	<p>facility representative will complete the assessment (bed rail/assist bar evaluation) along with the current side rail assessment for each resident upon admission, quarterly and with any significant change in resident condition in order to assess the needs and safety for each individual resident. Completion of the bed rail/assist bar evaluation and side rail assessment was added to the nursing admission checklist on 3-2-15. Maintenance director and administrator will monitor beds and mattresses. An all staff in-service was on 3/4/15 to educate staff on the risk of accident hazards, entrapment and bed safety. Any problems or concerns will be brought to the QAPI committee to be addressed, reviewed and to provide further recommendation.</p> <p>Storage of cleaning chemicals: Administrator provided education to housekeeping staff on the proper storage of cleaning chemicals on 3-6-15. Administrator will spot check housekeeping carts for proper storage of cleaning chemicals 3 times per week X 1 month, then</p>	
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F 323	<p>Continued From page 47</p> <p>for transferring from one area to another, ambulation, dressing, toilet use, personal hygiene, and bathing.</p> <p>-She was unsteady.</p> <p>-She was occasionally incontinent (unable to control) of urine.</p> <p>-She had a fall history prior to admission to the facility.</p> <p>-She had received antipsychotic (mood altering drug), antianxiety, and antidepressant medications.</p> <p>-Bed rails were marked as "not used."</p> <p>*The 3/13/14 Care Area Assessment (CAA) identified cognition impairment, visual function, communication, urinary incontinence, behavior symptoms, falls due to unsteadiness, psychotropic drug use, and falls. Physical restraints were not marked.</p> <p>*11/20/14 quarterly MDS revealed:</p> <p>-The BIMS score was five.</p> <p>-She required extensive assistance of one staff person with bed mobility, dressing, toilet use, bathing, and transferring.</p> <p>-She required limited assistance of one with ambulation.</p> <p>-She was unsteady.</p> <p>-She was frequently incontinent of bowel and bladder.</p> <p>-Bed rails were marked as "not used."</p> <p>Review of the following fall risk evaluations revealed resident 8 scored eighteen on 3/11/14, seventeen on 6/3/14, fifteen on 8/21/14 and 11/13/14. A score of ten or above represented a high fall risk.</p> <p>Review of the consent for use of side rails signed by the MDS coordinator and resident 8's daughter with a date of 3/4/13 (resident 8 had been</p>	F 323	<p>once monthly X 3 months.</p> <p>Compliance during spot checks will be reported to the QAPI committee for review and further recommendation.</p> <p>Biohazard waste bin:</p> <p>The biohazard waste bin in the southwest soiled utility room is secured (locked) from residents. There are 5 keys for this lock. Maintenance manager, housekeeping manager, DON and administrator maintain a key. The other key is located on the nurse's key ring. Any staff member that needs to fill biohazard waste bin must request nurse, maintenance manager, housekeeping manager, DON or administrator to unlock the bin to place material in bin, which is immediately re-locked to ensure resident and staff safety. To sustain compliance, the maintenance manager will check the bin each week that the lock remains in place and secured when not being filled or emptied. Maintenance Administrator provided education on biohazard waste bin securing on 3-4-15 at the inservice training for all staff. A policy and procedure was developed for the biohazard waste</p>	
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F 323	<p>Continued From page 48 admitted on 3/4/14) revealed: *Recommendations marked were to use a 1/2 partial rail for left upper and right upper sides of the bed. *Frequency recommended was at all times when the resident was in bed. *Purpose for side rail use was for repositioning. *The side rails had been requested by resident 8's daughter for security and rolling out of bed. *The side rails had been assessed by the MDS coordinator on 3/4/14, 6/3/14, 8/21/14, and 11/13/14 for the stated purpose of repositioning.</p> <p>Review of resident 8's updated 8/27/14 care plan approaches included side rails: use side rails to help with repositioning in bed.</p> <p>Interview on 2/4/15 at 4:30 p.m. with the administrator, DON, and MDS coordinator revealed: *The MDS coordinator: -Had done the educational piece of side rail usage for the residents. -Had been unaware of the safety assessment piece for side rail usage. *The DON: -Had never had side rail safety issues brought to her attention. -The facility had used the Hil-Rom beds since 2005.</p> <p>Surveyor: 35120 Preceptor: 29354 2. Observation on 2/4/15 at 3:25 p.m. of resident 1's room revealed: *She had a Hil-Rom bed with four 1/2 side rails attached to it. *The two 1/2 side rails at the top of the bed were in the raised position.</p>	F 323	<p>bin on 3-2-15. To monitor that requirements are met, the maintenance manager will audit the biohazard waste bin lock 1x/week for one month and monthly thereafter for 3 months. The maintenance manager will report audit results to the QAPI committee for review at monthly QAPI meeting. The QAPI committee will evaluate the plan for continued compliance and effectiveness. Based on findings, the QAPI committee will make recommendations to continue or discontinue audits.</p> <p>Door alarms: To be compliant with this finding: The exit door alarm on the southwest wing is activated and is monitored by nursing staff continuously. To sustain compliance, the nurse will check the alarm panel each shift that the door alarms remain activated. Administrator provided education to all staff on alarm system/ panel and reviewed the policy on door alarms 3-4-15 at the staff inservice. To monitor that requirements are met, the maintenance manager will audit the alarm panel 3x/ week for one</p>		

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F 323	<p>Continued From page 49</p> <p>Review of resident 1's medical record revealed: *An admission date of 9/28/12. *She had diagnoses of osteoarthritis (disease of the joints, involves pain and stiffness of affected joints), diaphragmatic hernia (when one of the abdominal organs moves up into the chest through an opening), renal failure (decreased kidney function), hypertension (high blood pressure), coronary atherosclerosis (plaque build up in the hearts arteries), hypothyroidism (decreased thyroid function), type two diabetes (chronic condition in the way the body processes sugar), colon cancer, hyperlipidemia (high fat levels), anxiety, depression, low vitamin D, and vascular dementia (decline in thinking skills). *She had been readmitted on 11/14/14 from the hospital after she had fallen and fractured her hip that required surgery.</p> <p>Review of resident 1's 1/10/15 MDS assessment revealed she: *Had a BIMS score of five (indicates severe mental impairment). *Required extensive assistance with two staff members for: -Bed mobility. -Transfers. -Toilet use. -Personal hygiene. -Bathing. *Was frequently incontinent of urine and occasionally incontinent of stool. *Had occasional pain. *Had a fall since her last assessment on 11/21/14. *Had one unstageable pressure ulcer (skin/tissue damage where the depth is unable to be seen). *Had been using a pressure reducing device for</p>	F 323	<p>month and weekly thereafter. The maintenance manager will report audit results to the QAPI coordinator for review at monthly QAPI meeting. The QAPI committee will evaluate the plan for continued compliance and effectiveness. Based on findings, the QAPI committee will make recommendations to continue or discontinue audits.</p> <p>Light fixture in southwest utility room: To be compliant with this finding: Maintenance director installed a protective cover to the light fixture in the west soiled utility room on 2-7-15. Maintenance manager will audit lighting throughout the building by checking west wing, east wing, east wing offices, and north wing-one wing per week for 1 month, then monthly spot checks for 3 months. Maintenance manager will report audit findings to the QAPI committee monthly for review and further recommendations.</p>	
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F 323	<p>Continued From page 50 her chair and receiving pressure ulcer care.</p> <p>Review of resident 1's 7/10/14 care plan revealed she: *Required extensive assistance of one staff person. *Could help to reposition herself by using the side rail. *Used side rails at night to help with repositioning. *Was unable to get out of bed on her own.</p> <p>Review of resident 1's following fall risk evaluations revealed scores of: *Nineteen on 6/26/14. *Seventeen on 9/18/14. *Twenty on 11/21/14. *A total score of ten or above represented a high risk for falls.</p> <p>Review of resident 1's 1/29/15 physician's orders revealed "May have 1/2 rail for repositioning."</p> <p>Review of resident 1's 7/29/13 consent for and evaluation of side rails revealed: *She had requested the use of side rails for security. *She had been unaware of safety needs. *The side rails had been recommended at all times when she was in bed. *The side rails to have been used were 1/2 partial rails on both the right and left tops of the bed. *She had been the one to sign the consent that stated she understood the risks and benefits of using side rails.</p> <p>3. Observation on 2/5/15 at 8:45 a.m. of resident 9's room revealed: *She was asleep in bed. *She had a Hil-Rom bed that had four 1/2 side</p>	F 323		

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F 323	<p>Continued From page 51</p> <p>rails attached to it. *The two top 1/2 side rails were in the raised position.</p> <p>Review of resident 9's medical record revealed: *An admission date of 4/30/13. * She had diagnoses of type two diabetes, hyperlipidemia, depression, hypertension, depression, femur fracture (broken leg bone), adrenal deficiency (production of certain hormones are affected), anemia (low blood count), leukocytes (white blood cell that indicates infection), reactive confusion, trigeminal neuralgia (chronic pain condition of a facial nerve), macular degeneration (vision loss), chronic kidney disease (decreased kidney function), coronary artery disease (hardening of the heart arteries), and osteoporosis (fragile bones).</p> <p>Review of resident 9's 11/27/14 MDS assessment revealed she: *Had a BIMS score of 15. *Required limited assistance of one staff member to help her. *Had been continent (able to control) of bowel and bladder. *Had no pain, falls, or pressure ulcers.</p> <p>Review of resident 9's 10/24/13 care plan revealed there had been no documentation of side rails being used.</p> <p>Review of her 1/29/15 physician's orders stated "side rails used for repositioning."</p> <p>Review of resident 9's consent/evaluation for use of side rails showed: *She had requested the side rails for safety, and she had a family member request them for</p>	F 323		

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F 323	<p>Continued From page 52</p> <p>security.</p> <p>*She had 1/2 partial rails on both the left and right upper parts of the bed</p> <p>*Side rails had been recommended at all times when she was in bed.</p> <p>*Her family member had signed the consent and not the resident.</p> <p>Interview on 2/4/15 at 3:00 p.m. with resident 9 revealed:</p> <p>*She asked staff every night to put up her side rails.</p> <p>*She lowered the side rails herself in the morning.</p> <p>*She refused to go to sleep without the side rails up.</p> <p>Surveyor: 32355</p> <p>4. Random observations from 2/3/15 through 2/5/15 and testing of resident 3's bed revealed:</p> <p>*Four Hil-Rom 1/2 side rails were attached to his bed.</p> <p>*Two of the 1/2 side rails had been attached to the head of his bed and were in the up position at all times.</p> <p>*The other two 1/2 side rails had been attached to the foot of his bed. They had been in the down position.</p> <p>*The side rails had four openings within the outer frame, and testing revealed a head would fit through those openings.</p> <p>*While sitting on the resident's bed testing revealed between the mattress and the side rail there was enough room for a person's thigh to slide through that space.</p> <p>*Testing revealed when both of the side rails were in the up position a head would fit through the space in between them.</p> <p>Review of resident 3's complete medical record</p>	F 323		
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F 323	<p>Continued From page 53</p> <p>revealed:</p> <ul style="list-style-type: none"> *An admission date of 11/30/11. *Diagnoses of dementia (forgetfulness) with behavioral disturbances, history of respiratory (lung) infections, bilateral (both) inguinal scrotal hernia (soft tissue protruding through the muscle), dysphasia (swallowing difficulties), abnormal body movements, and glaucoma (poor vision). *The 1/5/15 physician's order stated to "Have side rails up while in bed for positioning." <p>Review of resident 3's 11/20/14 MDS revealed:</p> <ul style="list-style-type: none"> *He was hard of hearing and rarely understood others. *His vision was highly impaired. *He had not been able to be interviewed to establish his current memory recall. *He was unable to ambulate and had required extensive assistance of two staff persons for transfers and moving in bed. *Bed rails were marked as "not used." <p>Review of resident 3's 8/28/14 evaluation for use of side rails revealed:</p> <ul style="list-style-type: none"> *The use of the side rails had been documented for "Medical symptoms." *The medical symptoms identified had been for weakness and unable to support trunk (upper body) in an upright position. *He had been identified as "Unaware of safety needs." *The side rails were to have assisted him with: <ul style="list-style-type: none"> -Repositioning from side-to-side while in bed. -Avoiding rolling out of bed with a comment of "Resident does swing leg over side, turn noodle [used for repositioning] placed under mattress." -Providing a sense of security. *He was incontinent of both bowel and bladder 	F 323		

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F 323	<p>Continued From page 54 and had been dependent upon staff to meet his toileting needs.</p> <p>*He was having a decline in cognitive (memory) status with a comment of "According to history dementia is progressing."</p> <p>*Recommendations marked were to use 1/2 partial side rails for left upper and right upper.</p> <p>*The side rails had been assessed for repositioning by the MDS coordinator on 3/3/14, 6/5/14, and 8/28/14.</p> <p>No signed consent form for the use of the side rails had been located in his active chart.</p> <p>Interview on 2/5/15 at 2:00 p.m. with the social services worker revealed they were unable to locate a signed consent form for the use of his side rails. She confirmed someone would have had to sign the consent form for resident 3 to use the side rails due to his mental status and diagnosis of "Alzheimer's [memory loss]."</p> <p>Review of resident 3's 9/2/14 care plan revealed: *A problem of "Alteration in mobility R/T [related to] movement disorder and advanced dementia." *A goal of "Use of side rails daily through next 90 days." *An approach of "Side Rails: Half rails up on bed to assist resident with some movement, will also hold onto rail during cares."</p> <p>Observation on 2/3/15 at 4:05 p.m. with certified nursing assistants (CNA) C and D with resident 3 revealed: *They had been preparing to assist him with transferring out of bed. *He had been laying in bed and required CNA C and D to assist him with turning and sitting up on the edge of the bed.</p>	F 323		

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F 323	<p>Continued From page 55</p> <p>*They had not cued him to use the side rail to help assist them with turning and sitting up. *He had made no attempt to use the side rail while the CNAs assisted him with repositioning and transferring him out of the bed.</p> <p>Interview on 2/4/15 at 3:15 p.m. with CNA C regarding resident 3 revealed he: "Does not use the side rails for sitting up or moving in bed." She had not attempted to cue him to see if he could use the side rails. She "thought he probably could with cueing, but wasn't sure."</p> <p>5. Random observations from 2/3/15 through 2/5/15 of resident 5's bed revealed: *Two Hil-Rom 1/2 side rails were attached to the head of his bed. *They were in the up position at all times.</p> <p>Review of resident 5's complete medical record revealed: *An admission date of 5/17/13. *Diagnoses of Parkinson (tremors with muscle stiffness), dementia with behavioral disturbances, and mood disorder with hallucinations (sees or hears objects or people that are not there). *He had been currently taking psychotropic (mood altering) medications.</p> <p>Review of resident 5's 1/8/15 quarterly MDS assessment revealed: *He had: -Impaired vision and could read large print. -Required extensive assistance of one or two staff persons for moving in bed and transfers. -Range of motion (ability to move freely) limitations to both of his legs. -Received antianxiety and antidepressant medications.</p>	F 323		
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F 323	<p>Continued From page 56</p> <p>*The bed rails were marked as "not used."</p> <p>Review of resident 5's 10/21/14 care plan revealed no documentation to support the use of the side rails.</p> <p>Review of the consent for use of side rails signed by the MDS coordinator and resident 5 dated 5/20/13 revealed: *Recommendations marked were to use 1/2 partial rails for left upper and right upper sides of the bed. *They had been recommended for night use only. *The purpose for the side rail use was for repositioning.</p> <p>Review of resident 5's 1/8/15 Evaluation For Use of Side Rails form revealed: *The side rails had been requested by the resident for weakness, balance problem, and pain. *He was to use the side rails to help with moving in bed, transfers, avoid rolling out of bed, and for a sense of security. *The side rails had been assessed by the MDS coordinator on 5/1/14, 7/24/14, 10/16/14, and 1/8/15.</p> <p>Observation on 2/3/15 at 1:45 p.m. of resident 5 revealed: *He was laying in bed resting. *Both of the 1/2 side rails were in the up position. *Both of his legs were hanging over the edge of the bed. This had created a potential hazard related to the position of the upper side rails.</p> <p>6. Random observations on 2/4/15 of resident 7's bed revealed two Hil-Rom 1/2 side rails that were in the up position at the head of the bed.</p>	F 323		

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F 323	<p>Continued From page 57</p> <p>Review of resident 7's complete medical record revealed: *An admission date of 12/29/11. *Diagnoses of a blood clot in the left leg, dementia, anxiety, and depression (sadness). *The 2/3/15 physician's orders stated "May have side rails for repositioning." *She had been currently taking psychotropic (mood altering) medications.</p> <p>Review of resident 7's 1/1/15 quarterly MDS assessment revealed: *Her BIMS was a two indicating severe cognitive impairment. *She required extensive assistance of one to two staff persons for moving in bed and transfers. *Her balance was unsteady. *She had a history of falls. *She had received antipsychotic (mood altering) and antidepressant medications. *The bed rails were marked as "not used."</p> <p>Review of resident 7's 7/22/14 care plan revealed an approach stating "Side rails: not used." That documentation had two lines drawn through it with D/C'd (discontinued) written beside it. The D/C'd documentation had no date located beside it to indicate when they had been discontinued.</p> <p>Review of the consent for use of side rails signed by the MDS coordinator and resident 7's son on 12/28/11 revealed: *Recommendations marked were to use 1/2 partial rails for left upper and right upper sides of the bed. *The frequency recommended was for at all times when the resident was in bed. *The side rails were to have been used as a</p>	F 323		

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F 323	<p>Continued From page 58 mobility aid.</p> <p>Review of resident 7's 12/31/14 evaluation for use of side rails revealed: *The family had requested the use of the side rails for security. *She had been unaware of safety needs. *She was to use the side rails to help with bed mobility, transfers, avoid rolling out of bed, and provide a sense of security. *The cognitive status indicated she had dementia. *The side rail precautions and alternatives for side rails had been discussed with the son. *The side rails had been assessed by the MDS coordinator on 4/24/14, 7/17/14, 10/9/14, and 12/31/14.</p> <p>7. Interview on 2/5/15 at 8:30 a.m. with the MDS coordinator revealed: *She had been responsible for the assessments and evaluations of the side rails on the residents. *She had not assessed the residents for the safety risk on using the side rails. *She had not been aware of any safety concerns or risks with the current side rails and mattresses they had been using. *She had not been aware of the risks or of the potential for the residents of getting their head through the Hil-Rom side rails.</p> <p>Review of the provider's updated 2/4/15 Policy and Procedure on Side Rails revealed: *"Each resident will be provided with a hospital type bed which if appropriate for use according to side rail assessment." *"If side rails are needed for own bed they may be ordered." *"All side rails must fit bed properly not to pose an injury to resident or staff."</p>	F 323		
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F 323	<p>Continued From page 59</p> <p>*"Side rails may be used to enable resident independence or when specifically requested by the resident or in an emergency."</p> <p>B. Based on observation, interview, and policy review, the provider failed to ensure:</p> <p>*The storage of cleaning chemicals for one of one housekeeping cart (southeast wing) had been locked and secured from residents access.</p> <p>*Exposed light bulbs had a protective cover in one of two observed soiled utility rooms (southwest wing).</p> <p>*One of one biohazardous (infectious waste) waste bin was secured from residents and all staff access in the southwest soiled utility room.</p> <p>*One of four observed exit doors (southwest wing) security alarm had activated and sounded upon opening.</p> <p>Findings include:</p> <p>1. Random observations on 2/3/15 from 8:10 a.m. through 1:45 p.m. of a housekeeping cart located on the southeast wing revealed:</p> <p>*It had been observed in various locations on the southeast wing.</p> <p>*No housekeeping staff had been in attendance or monitoring that cart during any of the observations.</p> <p>*The housekeeping cart had been unlocked and contained the following chemicals:</p> <ul style="list-style-type: none"> -One spray bottle of Sanicare TBX disinfectant cleaner. -One spray bottle of Sparkle acid cleaner. -One spray bottle of Quaternary disinfectant cleaner. -One spray bottle of Multi-purpose nonconductive surface cleaner. <p>*All of the labels on the above chemicals read "Keep out of the reach of children."</p>	F 323		
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F 323	<p>Continued From page 60</p> <p>*Several residents were observed wandering up and down the hallway in the area of the housekeeping cart.</p> <p>Interview on 2/4/15 at 9:10 a.m. with the housekeeping supervisor revealed the housekeeping cart should have been locked when not in attendance.</p> <p>Review of the provider's undated Housekeeping and Maintenance Department Responsibilities policy revealed "Chemicals must be either in your possession or locked in the appropriate cabinet at all times."</p> <p>2. Observation on 2/3/15 at 8:20 a.m. of the soiled utility room located on the southwest wing revealed: *The entrance door into the soiled utility room had been unlocked. *A light fixture attached to the ceiling had no protective cover over the light bulbs.</p> <p>Interview on 2/5/15 at 9:05 a.m. with the administrator, maintenance supervisor, and DON revealed they had not been aware the light fixture did not have a protective cover. They agreed the light fixture should have had a protective cover over the light bulbs to ensure safety from the potential of the bulb breaking resulting in injury.</p> <p>3. Observation on 2/10/15 at 8:15 a.m. of the soiled utility room located on the southwest wing revealed: *The entrance door into the soiled utility room had been unlocked. *Inside that room there had been a large red biohazardous (infectious materials) waste garbage bin. The lid was unlocked and easily</p>	F 323		

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F 323	<p>Continued From page 61 opened. *Inside that bin were two small red biohazardous waste containers. Those waste containers had been: -Covered with white plastic lids to enclose the contents inside the containers. -Filled with used syringes, needles, and small glass vials. -Small enough to pick-up and take out of the room.</p> <p>Interview on 2/10/15 at the time of the above observation with the maintenance supervisor revealed: *The soiled utility room had always been unlocked. *Any staff member or any resident could have entered the soiled utility room at any time. *He had not considered the biohazardous waste garbage bin or containers a safety risk for the residents or a drug diversion issue with staff. *He agreed the garbage bin and containers should have been secured from resident and staff access.</p> <p>The provider had been unable to provide this surveyor with a policy and procedure for the security of biohazardous materials during the survey or upon request.</p> <p>4. Observation on 2/3/15 at 8:10 a.m. on the southwest wing revealed: *Two closed wooden doors at the end of the hallway. *A Wanderguard (wireless monitoring system for residents at risk of wandering) sounding device was attached to them. *The doors were unlocked and when they were opened the sounding device would make a loud</p>	F 323		
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F 323	<p>Continued From page 62 noise.</p> <p>*The doors opened to a small enclosed area revealing a steel door. That door had been labeled as an exit door.</p> <p>*An alarm did not sound when that exit door had been opened by this surveyor.</p> <p>*The exit door opened to a snow-covered flight of steps leading to the back of the building.</p> <p>*The back of the building had not been secured and was located by a garage and an apartment complex.</p> <p>Interview on 2/3/15 at the time of the above observation with CNA F and the laundry supervisor confirmed:</p> <p>*The exit door had not alarmed upon opening.</p> <p>*The exit door should have alarmed at the nurses station when opened.</p> <p>*There had been an unidentified and confused resident who resided in a room next to the exit door. His wife shared a room with him and watched over him.</p> <p>Interview on 2/10/15 at 9:10 a.m. with the administrator and maintenance supervisor confirmed the above interview. The checking of the exit doors had been on the maintenance supervisor's check list to monitor for security and alarming. They would have expected the exit door to alarm upon opening to ensure the safety of the residents.</p> <p>Review of the provider's undated Door Alarm System policy revealed:</p> <p>***All exit doors to the facility also have a separate buzzer system which is regulated on a panel by the nurses station.</p> <p>***The southwest and southeast alarms are on 24 hours a day.</p>	F 323		
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F 323	Continued From page 63 *"The health care team at [provider name] is committed to the safety of the residents while maintaining their level of function."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, record review, interview, and policy review, the provider failed to ensure a psychotropic (mood altering) medication had	F 329	F329 <u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u> Resident #8 chart and medication list was reviewed by her physician on 3/3/15. The medication Haldol was discontinued from use. On 2/25/15 the order was received for this resident to be referred to Northeastern Mental Health (NEMH) to review her medications and diagnoses. This will be completed on 3/26/15 as this is the first available time she can be seen by NEMH. NEMH sees the majority of the facility residents who receive any psychotropic medication. DON	3/13/2015

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F 329	<p>Continued From page 64</p> <p>been administered with appropriate diagnosis, monitoring, and rationale (reason) for one of five sampled residents (8) receiving a psychotropic medication. Findings include:</p> <p>1. Random observations from 2/3/15 through 2/5/15 and on 2/10/15 of resident 8 revealed she was in her room or at the dining room table during mealtime. During those observations she had not displayed behaviors of anxiety or agitation.</p> <p>Review of resident 8's medical record revealed she had been admitted on 3/4/14 with: *Diagnoses of dementia (state of confusion), depression, and anxiety. *Physician's orders for the following medications: Haldol (antipsychotic) for anxiety, lorazepam (for anxiety), and mirtazapine (antidepressant).</p> <p>Review of resident 8's behavior sheets, physician's orders, nurses notes, pharmacy notes, and physician's progress notes from March 4 through 31, 2014 through January 2015 revealed: *March 4 through 31, 2014: -The behavior sheets showed four out of twenty-eight days with anxiousness and ten out of twenty-eight days with repetitive verbalization. -The Medication Administration Record (MAR) revealed she had received Haldol once and lorazepam seventeen times. The as needed (prn) sheet stated Haldol had been given for anxiousness. *April 2014: -There was no documentation on the behavior sheet, however lorazepam had been given twice for restlessness. *May 2014: -There was no documentation on the behavior</p>	F 329	<p>and pharmacist met on 3/5/15 to discuss how medication use and proper diagnosis for medications can be monitored. A memorandum was distributed to the licensed nurses on 3/5/15, which included proper documentation of use of antipsychotics and documentation on the behavior sheets. This memorandum included an agreement page that must be signed and returned to DON by 3/13/15. On 3/10/15, DON and pharmacist will review those residents who receive an "as needed/PRN" psychotropic medication for proper diagnosis, documentation, and use of the medication. A more focused review of medications will then be part of the monthly pharmacist review. The form used for pharmacist reviews has places for documentation and monitoring and will be used more completely. The DON will make a weekly review of at least 1 resident chart that has received a PRN psychotropic medication for proper documentation and use of that PRN medication. This review will be brought to the QAPI committee</p>	

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F 329	Continued From page 65 sheet, however lorazepam had been given twice for restlessness. *June 2014: -There was no documentation on the behavior sheet, however lorazepam had been given once. -Haldol prn had been discontinued on 6/23/14. *July 2014: -The behavior sheet revealed on July 28 she had wandering, pacing, hallucinations, and delusions marked five times; sleep disturbance marked ten times. On July 29 delusions were marked five times. -The 7/28/14 MAR documented lorazepam had been given once. The nurse's note stated "Was up all night with restless, confused but in a good mood. Increased confusion looking for dtr [daughter] et [and] mother." -The 7/28/14 nurse's note stated "Res [resident] confused this AM. Looking for dtr et mother. Freq [frequent] setting off tabs alarms. Contacted DR [doctor]. Awaiting response." -The 7/29/14 nurse's note stated "Has been awake and restless all night since 11:15 p.m. has been in a good mood but very confused." -A new physician's order dated 7/30/14 for Haldol 0.5 milligrams (mg)-take 1/2 tablet po (by mouth) every 6 hours prn for confusion/anxiety. *August 2014 - There was no documentation on the behavior sheet. *September 2014 - There was no documentation on the behavior sheet. *October 2014: -The behavior sheet documented verbally abusive, hallucinations, and delusions on the 13 and 14. Sleep disturbance was marked four times. -The MAR revealed Haldol had been documented five times as being given and lorazepam five times as having been given.	F 329	where the need for further reviews will be addressed and changes made as indicated. This is our allegation of compliance.		

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F 329	<p>Continued From page 66</p> <p>-The 10/13/14 nurse's note stated "Resident restless and agitated at HS [bedtime] this evening."</p> <p>-The 10/15/14 nurse's note stated "At supper behavior was more typical for her but she was a little "drugged" acting. She was slow, a little diff [different] ambulating, quiet."</p> <p>-On 10/16/14 the physician was notified regarding resident 8's condition being lethargic (tiredness or lack of energy) and unable to ambulate.</p> <p>-Physician's order on 10/15/14 was to schedule Haldol 0.5 mg po TID (three times a day) in addition to the current prn order.</p> <p>-Physician's order on 10/16/14 was to DC (discontinue) current order for Haldol 0.25 mg prn and 0.5 mg TID. Change Haldol order to 0.5 mg po TID prn.</p> <p>*November 2014 - The behavior sheet had abusive marked once.</p> <p>*December 2014:</p> <p>-The behavior sheet had multiple days of verbally abusive, repetitive verbalizations, and sleep disturbance marked.</p> <p>-The 12/2/14 physician's progress note stated "Her scheduled Haldol was discontinued due to side effects. She still has prn Haldol available. Current psychotropic usage: Aricept for dementia, Remeron for depression, and Haldol discontinued. Assessment: Dementia with behavioral disturbance."</p> <p>Interview on 2/10/15 at 10:00 a.m. with licensed practical nurse G regarding resident 8 confirmed:</p> <p>*The resident had been on scheduled Haldol when she was admitted.</p> <p>*Haldol had been discontinued but then restarted in July 2014.</p> <p>*She agreed the behavior sheets had not included enough documentation for the use of the</p>	F 329		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 67</p> <p>Haldol. *Haldol had been rescheduled in October 2014. Resident 8 had become "snowed [very sleepy]" from the medication. but the scheduled dose had been discontinued.</p> <p>Review of resident 8's April 2014 through January 2015 monthly pharmacy documentation form revealed the recommendations "none" had been documented each month.</p> <p>Telephone interview on 2/10/15 from 12:50 p.m. through 1:25 p.m. with the consulting pharmacist revealed he: *Had not documented any recommendations for psychotropic medications. *Agreed he probably should have documented on those medications.</p> <p>Interview on 2/10/15 at 1:45 p.m. with the director of nursing regarding resident 8 confirmed: *The resident had been "snowed" from the scheduled Haldol. *There was a moment in time when the resident had needed the Haldol. *She felt when the resident needed the Haldol "she needed it now." *The resident had not received mental health services since admission. *She felt the resident had the appropriate diagnosis for the use of an antipsychotic medication.</p> <p>Review of the provider's undated Antipsychotic Use policy and procedure revealed: **Residents of [name of facility] will receive antipsychotic drugs only when justified by a specific condition, and only in conjunction with gradual dose reductions.</p>	F 329		
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F 329	Continued From page 68 *The nurse with primary responsibility for the resident will work together with the pharmacist and the physician in targeting residents for evaluation and subsequent care planning in this area."	F 329			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater: This REQUIREMENT is not met as evidenced by: Surveyor: 35120 Preceptor: 29354 Based on observation, interview, record review, and policy review, the provider failed to ensure medications were administered with less than 5 percent (%) medication error rate. The provider's medication error rate was 6.8% for 2 of 29 observed medications administered to 2 randomly observed residents (11 and 15). Findings include: 1. Review of resident 11's medical record revealed: *On 1/30/15 the physician had ordered a sliding scale (amount of insulin given based on the blood sugar) insulin to be used with Humalog insulin for each meal and at bedtime as follows: -BS 200 to 250, 6 units -BS 251 to 275, 8 units -BS 276 to 300, 10 units -BS 301 to 325, 12 units -BS 326 to 350, 14 units -BS 351 to 400, 16 units -Call physician if blood sugar was over 400.	F 332	F332 Failure to follow professional standards for medication administration, properly written orders, implementing orders or discontinuance of orders: Nursing memorandum was created by DON on 3/3/15, which included information on professional standards. DON also created a memorandum for UAPs to include information on professional standards for proper medication administration. These memorandums were distributed to all licensed nurses and UAPs on 3/5/15 and agreement must be signed and returned to DON by 3/13/15. The nursing memorandum includes proper medication administration and documentation of administration, professional standards for writing up physician orders, how to monitor for those medications that have been discontinued and to	3/13/2015	

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F 332	<p>Continued From page 69</p> <p>*His medication administration record (MAR) on 2/3/15 at 5:30 p.m. had a documented blood sugar of 273 with 8 units of Humalog given.</p> <p>Observation on 2/3/15 at 5:32 p.m. of licensed practical nurse (LPN) A revealed she: *Checked resident 11's blood sugar and it was 278. *Wrote down on his MAR his blood sugar was 273. *Drew up 8 units of Humalog insulin and administered it to resident 11. *Had to write in his noon blood sugar and insulin as she had not done it earlier that afternoon right after she had administered it.</p> <p>Interview on 2/4/15 at 11:50 a.m. with LPN A revealed she: *Looked at resident 11's MAR and said his blood sugar was 273, that 8 units of Humalog had been given, and they were both accurate. *Reviewed the blood glucose history on the glucometer (device used to measure the blood sugar) and confirmed the blood sugar had in fact been 278. *Agreed the wrong blood sugar amount had been written down and the wrong dose of insulin had been given. *Changed the blood sugar on the MAR to reflect it was 278 and not 273.</p> <p>Interview on 2/4/15 at 3:42 p.m. with the director of nursing revealed she had been made aware of the medication error.</p> <p>Review of the provider's September 2010 Medication Administration Subcutaneous Insulin policy revealed: *"Check prescriber's order for insulin."</p>	F 332	<p>ensure the orders are implemented as directed.</p> <p>The 'medication administration evaluation' completed by the pharmacist quarterly will be used to evaluate the nurses medication pass by the DON. A medication pass evaluation will be done weekly or more often of varying nurses and UAPs until all are assessed. The medication administration evaluation will assess not only the med pass at mealtimes but also blood sugars and correct eye, nasal and nebulizer medication administrations. This will be assessed weekly times 4 weeks and then will address with QAPI committee for further advice. Follow up and additional training will be addressed at that time if additional education is needed. Varying nurses/UAPs will be assessed weekly until consistent correct medication passes are observed, then monthly. Any concerns regarding the administration of medications will be addressed by the QAPI committee and changes made accordingly. Regarding properly written orders and the implementation of orders, the</p>	
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F 332	<p>Continued From page 70</p> <p>***Prepare injection.</p> <p>***Determine correct amount of insulin to be withdrawn.</p> <p>Surveyor: 29354</p> <p>2. Observation and interview on 2/3/15 at 10:25 a.m. with LPN A regarding resident 15 revealed she:</p> <ul style="list-style-type: none"> *Took a bottle of Gen Teal eye drops from the medication cart. *Went into the resident's room. *Administered the eye drops into both of the resident's eyes. *Confirmed she had placed one drop into each of the resident's eyes. *The MAR had not specified how many drops or which eye to administer the drops into. <p>Interview and observation on 2/4/15 at 10:30 a.m. with LPN G regarding resident 15 revealed:</p> <ul style="list-style-type: none"> *The MAR had not specified how many eye drops or which eye to administer the eye drops into. *They usually used the eye drop box for determining the amount of drops to use. *She removed the pharmacy label from the box and read from the box to instill "one to two drops in affected eye." <p>Review of resident 15's medical record revealed:</p> <ul style="list-style-type: none"> *A physician's order for Gen Teal Lubricant eye drops BID (twice daily). *The order had not specified how many drops to apply and not to which eye. <p>Telephone interview on 2/10/15 from 12:50 p.m. through 1:25 p.m. with the consultant pharmacist revealed he thought he looked at medication error reports when at the facility but was not sure.</p>	F 332	<p>nurses complete a physician's orders checklist when taking off orders. Changes have been implemented to this form to make sure the five rights are included in the order to make sure all orders are written and implemented properly. This is to be done with each order. DON will complete random reviews of new admission and hospital returns, as well as completing random review of orders. Any problems that are noted will be brought to the QAPI committee and addressed at that time. Regarding self-administration of medications: A new policy and assessment has been adopted by the facility to address those residents capable of administering their own medications once set-up is completed by the nurse or UAP. Orders have been obtained by the physicians and are included in revised "Standing Orders". Those deemed appropriate by the assessment completion, may take their medications at their leisure at the table or in their room and may be left unattended during nebulization therapy after set-up. This assessment will be</p>	
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F 332	Continued From page 71 Interview on 2/10/15 at 1:45 p.m. with the DON regarding resident 15 confirmed: *The amount of eye drops and which eye should have been specified. *When a medication error occurred the process was to fill out a medication error form, call or fax the physician, and see if anything needed to be done. *Medication errors were reviewed with the physician and the pharmacist. Review of the provider's October 2007 Eye Drop Medication Administration policy revealed to administer ophthalmic (eye) solution into eye in a safe and accurate manner. Review of the provider's updated April 2014 Adverse Consequences and Medication Error policy revealed: **The facility evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems such as adverse drug reactions (ADRs) and side effects. *Adverse consequences shall be reported to the attending Physician and Pharmacist, and to federal agencies as appropriate. *Example of medication errors include: -Wrong dose. -Wrong dosage form. -Failure to follow manufacture instructions and/or accepted professional standards."	F 332	completed by the DON or other designated licensed nurse upon admission and quarterly, as well as with any significant changes. Any concerns or changes will be brought to the QAPI committee for review monthly for four months.		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371	F371 Maintain proper sanitizing of the wiping cloths: The sanitizing buckets will be available during	3/13/2015	

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F 371	<p>Continued From page 72 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on observation, interview, and policy review, the provider failed to ensure: *Handwashing and glove use occurred appropriately when dishing up food during two of two meal services observed. *Wiping clothes were kept in sanitizing solution when not in-use in the kitchen. *The ice machine was sanitized per the manufacturer's instructions. Findings include:</p> <p>1. Observation on 2/3/15 during the noon meal service and the evening meal service revealed cook H: *Used numerous pairs of gloves throughout the dishing up of residents' food. *Consistently had not washed her hands prior to putting gloves on or after removing her gloves. *When she washed her hands she consistently turned the water faucet off with her clean hands.</p> <p>Observation on 2/3/15 during the evening meal service revealed dietary aide I after washing his hands consistently turned the water faucet off with his clean hands.</p> <p>2. Random observation throughout the survey revealed wiping clothes on the back kitchen</p>	F 371	<p>the kitchen and dining shifts. Wiping cloths are clean, rinsed frequently in a sanitizing solution and stored in the bucket of sanitizing solution between uses. The sanitizing buckets will be checked daily for appropriate sanitization solution per the test strips and changed according to the test strip results or sooner if visibly dirty. Documentation of the test strip checks and results will be logged and acted upon by the dietary staff. Hand washing and glove use occurs appropriately when plating food: Staff will perform proper hand washing and glove use when plating food during meal services. The ice machine was sanitized by the maintenance manager on 2-12-15 according to manufacturer's instructions. The ice machine will be sanitized according to manufacturer's instructions a minimum of twice per year and recorded when done. In-service: Education of policy for kitchen sanitation, dress code, hand washing, glove use, sanitizing solution with test strip checks, and ice machine sanitizing as well as appropriate use of</p>	
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F 371	Continued From page 73 counter and on the food preparation counter. The wiping clothes had not been observed kept in sanitizing solution when not in-use. 3. Interview on 2/4/15 at 3:40 p.m. with the certified dietary manager revealed: *The ice machine had not been sanitized on a regular basis. She was not aware of the manufacturer's instructions to clean the ice machine at a minimum of twice a year. *Staff members should have washed their hands before putting on gloves and after removing the gloves. *Following handwashing the water faucet should not have been turned off using clean hands. Review of the provider's policies and ice machine manufacturer's instructions revealed: *The undated Use of Gloves policy stated "Wash hands after removing the gloves and prior to putting new gloves on." *The 1/15/12 Handwashing policy stated a clean disposable hand towel should have been used to turn off the faucet. *The November 2008 Scotsman Ice Machine User Manual stated. "Maintenance and Cleaning/Sanitizing should be scheduled at a minimum of twice per year."	F 371	gloves and hand washing when plating food during meal services was provided to dietary staff by dietary manager on 3-11-15. Audits: the dietary manager is responsible for the audits to be completed and monitor appropriate use of gloves and hand washing and appropriate sanitizing solution and testing with the test strips and logging the test strip results. Audits will also include monitoring of the ice machine sanitizing and recording. Audits will be completed by the dietary manager weekly x 1 month, then monthly x 3 months. The dietary manager is responsible to report audit findings monthly to the QAPI committee for review and further recommendations.	
F 428 SS=F	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	F428 <u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is</u>	3/13/2015

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F 428	<p>Continued From page 74</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on interview, record review, and policy review, the provider failed to ensure monthly pharmacy consultations reported any irregularities or recommendations by the consulting pharmacist for eight of nine sampled resident's (1, 2, 3, 4, 5, 6, 8, and 9). Findings include:</p> <p>1a. Review of resident 6's medical record revealed: *An 11/19/14 admission date. *There was no pharmacy consultant reports for November and December 2014. *The January 2015 pharmacy consultant report under the comment section stated "none."</p> <p>b. Review of resident 8's medical record revealed: *An admission date of 3/4/14. *She received antipsychotic, antianxiety, and antidepressant (mood altering) medications.</p> <p>Review of resident 8's monthly pharmacy consultation reports from April 2014 through January 2015 revealed no documentation by the pharmacist to support the use of psychotropic (mood altering) medications.</p> <p>Telephone interview on 2/10/15 from 12:50 p.m. through 1:25 p.m. with the consultant pharmacist regarding resident 8 revealed he had not addressed the psychotropic medications and</p>	F 428	<p><u>prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u> Ensure monthly pharmacy consultations reported any irregularities or recommendations by the consulting pharmacist. DON met with pharmacist on 3-10-15 to review pharmacist duties. He was given the State Operations Manual for pharmacy with guidelines for pharmacy review. DON will audit reviews monthly X 4 months and report to the QAPI committee for further review and recommendation.</p>	
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F 428	<p>Continued From page 75 probably should have.</p> <p>c. Interview on 2/10/15 at 1:45 p.m. with the director of nursing (DON) revealed the consultant pharmacist had written "none" in the recommendation box for residents 6 and 8.</p> <p>Review of the provider's undated Antipsychotic Use policy and procedure revealed "The nurse with primary responsibility for the resident will work together with the pharmacist and the physician in targeting residents for evaluation and subsequent care planning in these areas."</p> <p>Surveyor: 35120 Preceptor: 29354</p> <p>3. Review of resident 1's medical record revealed: *Physician's orders for the following medications: -1/23/14 for Zoloft (for anxiety/depression) 50 milligrams (mg) by mouth (PO) every morning. -1/23/14 for Zoloft 100 mg PO every day at 3:00 p.m. -5/22/14 for Trazadone (for anxiety/depression) 25 mg PO every night. -5/22/14 for Lorazepam (for anxiety) 0.5 mg PO three times a day (TID). -10/22/14 for Buspar (for anxiety) 15 mg PO TID with meals.</p> <p>Review of the consulting pharmacist's monthly reports from January 2014 through January 2015 revealed he had documented: *January 2014 "None. Sertraline dose ok for diagnosis." *February 2014 "None." *March 2014 "Lorazepam appropriate based on diagnosis, maybe gradual dose reduction (GDR)</p>	F 428		
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F 428	<p>Continued From page 76 at night if appropriate." *April and May 2014 "None." *June 2014 "None" dose and tapering of Lorazepam was appropriate. *July 2014-January 2015 "None." *A GDR sheet filled out for Trazadone on 10/14/14 stated no GDR required at that time.</p> <p>4. Review of resident 9's medical record revealed physician's orders for the following medications: *4/30/13 for Oxycodone (for pain) one tablet (tab) PO every four hours PRN pain. *3/11/14 for Oxycodone 5 mg PO every night. *7/20/14 for Tramadol (for pain) 25 mg every four to six hours PRN.</p> <p>Review of the consulting pharmacists monthly reviews revealed from January 2014 though January 2015 he had documented "none" for every month.</p> <p>Surveyor: 18560</p> <p>5. Review of resident 4's medical record revealed: *Her February 2015 Medication Administration Record (MAR) listed ten scheduled medications and four prn medications. *Monthly documentation of review of her medications by the pharmacist from July 2014 through January 2015 noted under the comment section the word "none." *No further documentation was found the pharmacist had completed a thorough review of resident 4's medical condition and her medications.</p> <p>6. Review of resident 2's medical record revealed: *Her February 2015 MAR listed twenty-three</p>	F 428		
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NAME OF PROVIDER OR SUPPLIER STRAND-KJORSVIG COMMUNITY REST HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261
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F 428	<p>Continued From page 77</p> <p>scheduled medications and eight prn medications.</p> <p>*Monthly documentation of review of her medications by the pharmacist from July 2014 through January 2015 noted under the comment second the word "none."</p> <p>*No further documentation was found the pharmacist had completed a thorough review of resident 2's medical condition and her medications.</p> <p>Surveyor: 32355</p> <p>7. Review of resident 3's medical record revealed:</p> <p>*An admit date of 11/30/11.</p> <p>*He had a diagnosis of dementia (forgetfulness) and was not interviewable.</p> <p>*The staff had to anticipate his needs due to his communication deficit.</p> <p>*He had been dependent upon staff to meet all of his activities of daily living.</p> <p>*His January 2015 MAR listed eleven scheduled medications. One of those medications had been Tylenol (pain reliever) 650 milligrams orally twice a day.</p> <p>*He had been taking the scheduled Tylenol since 1/4/12.</p> <p>*On 1/19/15 he had been placed on comfort care (end-of-life) with all of his oral medications discontinued including the Tylenol.</p> <p>*The physician had ordered Ativan (antianxiety) 0.5-1.0 mg intramuscular (IM) every four hours as needed.</p> <p>*No medications had been ordered for discomfort.</p> <p>Review of resident 3's monthly pharmacy consultation reports from April 2014 through</p>	F 428		
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F 428	<p>Continued From page 78</p> <p>January 2015 revealed:</p> <p>*No documentation to support:</p> <ul style="list-style-type: none"> -The use of a psychotropic medication to be administered IM on a resident who was cognitively challenged and had communication deficits. -The discontinuation of a pain medication that the resident had been taking for some time. -Or encourage another type of pain medication for comfort during the resident's end-of-life. <p>*Under the comment section the word "none" had been written.</p> <p>*No further documentation was found to support the pharmacist had completed a thorough review of resident 3's current health and medical condition.</p> <p>8. Review of resident 5's medical record revealed:</p> <ul style="list-style-type: none"> *An admit date of 5/17/13. *Diagnoses of Parkinson (tremors with muscle stiffness), dementia with behavioral disturbances, and mood disorder with hallucinations (sees or hears objects or people that are not there). *He received antianxiety, antidepressant, and hypnotic (for sleep) medications daily. <p>Review of resident 5's monthly pharmacy consultation reports from April 2014 through January 2015 revealed no documentation to support the pharmacist had completed a thorough review of his medical condition or the use of psychotropic medications. Under the comment section of the reports the word "none" had been written in.</p> <p>9. Interview on 2/10/15 at 12:45 p.m. with the consulting pharmacist revealed:</p> <ul style="list-style-type: none"> *He had been the consulting pharmacist for this 	F 428		
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F 428	<p>Continued From page 79</p> <p>provider for approximately a year.</p> <p>*He came once a month to review all the resident medications.</p> <p>*He would have:</p> <ul style="list-style-type: none"> -Reviewed all of their medications and written down any recommendations or concerns. -Checked for any possible medication reactions and the need for a dosage reduction. -Destroyed medications with the DON. -Followed-up with the DON regarding any concerns. -Reviewed antianxiety medications every three months and psychotropic medications yearly for possible dosage reductions. <p>*He had not reviewed antidepressants. He had stated "Antidepressants are a vague issue and I'm not really for them. If the physicians order one for the elderly I'm okay with that."</p> <p>*He did not recommend Haldol as a scheduled medication for the elderly. If the Haldol had been ordered as needed that would be "okay."</p> <p>*He would not have reviewed a resident's chart for adequate pain management. He had stated "I feel doctors prescribe too many pain medications and the residents get addicted to them."</p> <p>*He had not consistently reviewed the provider's medication error reports. If he had seen the reports on the DON's desk, he would have checked them.</p> <p>*He had not reviewed residents' medications who were newly admitted in a timely manner. He came once a month and it could have been five weeks or better before he reviewed their medications.</p> <p>*He had not been familiar nor had any knowledge of any federal or state regulations and guidelines for consulting pharmacists.</p> <p>Interview on 2/10/15 at 1:30 p.m. with the</p>	F 428		
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F 428	Continued From page 80 administrator and DON regarding the above conversation with the consulting pharmacist revealed: *They had not been aware of his unfamiliarity or lack of knowledge regarding the state and federal guidelines for consulting pharmacists. The DON had reviewed these with him when he was first hired. *He had been given the medication error rate report to review. *Another pharmacy had filled and reviewed the resident's medications upon admit if they had been admitted at a skilled level of care. *Not all of their admissions had been admitted at a skilled level of care. Review of the provider's 12/16/13 signed Pharmacy Consulting Agreement by the administrator and pharmacist revealed no mention of any terms, conditions, obligations, and compliance regulations for the consulting pharmacy to follow.	F 428			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	F441 On 3-4-15, at the all staff inservice, DON discussed Infection Control policies that are in place. A new sign has been posted in the tub room: "Tub Cleaning/ Disinfect between Baths and Tub Disinfection at End of Day" that is now placed on the tub room wall and will provide employees with a reference to proper operation. The nursing department created a 'Cleaning	3/13/2015	

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F 441	<p>Continued From page 81</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions were maintained: *To prevent the potential for cross-contamination (transferring of bacteria from one resident to another) after disinfecting one of one whirlpool tub. *To prevent the potential for cross-contamination of clean resident use items stored in two of two observed soiled utility rooms (southeast and southwest). *For residents' personal care items in one of one</p>	F 441	<p>and Disinfection of Resident-Care Items and Equipment policy on 2-28-15. The nursing department created a Resident Personal Property policy on 2-28-15. Housekeeping replaced the chemical used to disinfect resident rooms, dining rooms, and all common areas. All products have been reviewed and approved. Personal cares: Failure to provide personal cares in a manner according to policy and procedures and to help prevent cross-contamination: Proper procedures were discussed with CNA C, D, F and J. In-service was presented on 3-4-15 regarding proper cares and thinking of each little step during procedures. Also discussed keeping clean things clean and what is soiled separate from clean. CNAs will be monitored for proper cares according to policy and procedures and current standards of practice to ensure that all residents receive proper care according to policy and procedures. A copy of this evaluation form was provided to all CNAs at the inservice on 3/4/15. Personal cares will be</p>	
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F 441	<p>Continued From page 82</p> <p>whirlpool tub room and one of one beauty salon. *To ensure five of five chemicals used to disinfect for highly infectious diseases were not outdated. *During personal care for one of one sampled resident (3) by four of four certified nursing assistants (CNA) (C, D, F, and J). *During a dressing change for one of one sampled resident (1) by one of one licensed practical nurse (LPN) (A). *To ensure the policy and procedure for the cleaning of the nebulizer apparatus had been followed after being used by two of two sampled residents (12 and 18) by one of one LPN (A). Findings include:</p> <p>1. Observation on 2/4/15 at 8:00 a.m. of CNA E during and after the disinfecting of the whirlpool tub on the southeast wing revealed: *She had just finished bathing a resident and was preparing to disinfect the whirlpool tub. *Without the use of gloves she: -Pushed the soiled whirlpool tub chair into the tub for disinfecting. -Shut the door attached to the whirlpool tub. -Turned a knob to allow for the water and spray hose to come on. -Sprayed the inside of the entire tub with the water/disinfectant mixture from the spray hose. -Retrieved a long handled scrub brush that had been laying on a shower chair. -Used the brush to scrub down the entire tub. -Touched several areas inside and outside of the tub during the cleaning process. -Opened a side door attached to the tub and placed the scrub brush inside. -Rinsed the tub with water immediately after scrubbing with the water/disinfectant cleaner. *She had used a chemical called Apollo Cid-A-L-II to clean the tub.</p>	F 441	<p>monitored and evaluated weekly by random selection of residents and staff for 3 months until next quarterly QAPI meeting. At that time if cares are being completed properly, the QAPI committee will decide at QAPI meeting when to stop monitoring of long-term CNAs, but will monitor new CNAs. Those responsible for evaluations will be DON and/or IC/QAPI coordinator. Failure to perform clean dressing change according to policy and procedure and current standards of practice: Correct procedure was reviewed with nurse A. Correct procedure was reviewed with all nurses. The policy was distributed to all nurses along with the evaluation form that will be used to evaluate nurses. This evaluation will take place weekly X 1 month. If evaluations show that nursing staff know how to complete a proper dressing change, will change to monthly evaluations. This will be evaluated in one year by the QAPI committee to see if continued monitoring is needed. The evaluations will be reviewed at each QAPI meeting also. Those responsible for evaluating the</p>		

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F 441	<p>Continued From page 83</p> <p>*The manufacturer's directions attached to the bottle required the chemical to remain wet and on all surfaces for ten minutes to ensure proper disinfecting.</p> <p>Interview on 2/4/15 at the time of the above observation with CNA E revealed she:</p> <p>*Would not have worn gloves during the disinfecting process of the whirlpool tub.</p> <p>*Agreed improper technique had been used and had created a potential for cross-contamination.</p> <p>*Had not been aware the chemical needed to remain wet and on all surfaces for ten minutes to ensure proper disinfecting.</p> <p>*Could not recall if she had been observed or audited while disinfecting the whirlpool tub to ensure the proper technique was used.</p> <p>*Retrieved several papers hanging on the wall by the tub.</p> <p>*Confirmed those papers contained information on the procedure for cleaning the tub.</p> <p>Interview on 2/10/15 at 8:55 a.m. with the administrator, maintenance supervisor, director of nursing (DON), and infection control nurse regarding the above observation revealed:</p> <p>*They had no documentation to support any education had been provided on the whirlpool tub cleaning.</p> <p>*The directions had been posted on the wall.</p> <p>*Staff were to have followed those directions.</p> <p>*There had not been any audits done on whirlpool tub cleaning.</p> <p>*They confirmed sanitary precautions had been broken.</p> <p>*There was potential for cross-contamination for any residents receiving a whirlpool tub bath after the cleaning and disinfecting process of the tub.</p>	F 441	<p>nurses will be the DON and/ or IC/QAPI coordinator. The nursing department created a Nebulizers (Updraft) policy on 2-9-15. The DON will evaluate this on her daily rounding sheets, which was created on 2-28-15. DON will report findings to the QAPI committee as identified above for review and further recommendations.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 441	<p>Continued From page 84</p> <p>Review of the provider's undated Tub Cleaning and Disinfecting procedure revealed no documentation to support how long the above chemical should have remained on all the surfaces.</p> <p>Review of a second provider's undated Tub and Cleaning/Disinfecting policy revealed: ***Put on gloves prior to disinfecting/cleaning tub." ***After each bath, you need to disinfect/clean tub and chair with TURBO KLEEN." ***Hold spray bottle of TURBO KLEEN 6-8" (inches) from surfaces and spray all surfaces of tub and chair with TURBO KLEEN." ***Scrub tub/chair with brush, and when tub/chair is clean, rinse with shower wand." *No documentation to support how long the chemical should have remained on all of the surfaces.</p> <p>Review of the 9/1/10 Whirlpool Tub Manufacturer's Operating Instructions revealed: *Rinsing Procedures "Allow contact time as detailed on disinfectant/cleaner." *On the side of this procedure was handwritten words with an arrow drawn and pointing to the above sentence stating "Contact time equals 10 minutes." *No documentation to support what type of chemical was to have been used.</p> <p>2. Observation on 2/3/15 at 8:20 a.m. in a soiled utility room located on the southwest wing revealed: *Two large bins filled with soiled linens. *A hopper (a object attached to a wall filled with water) with an attached spray hose for cleaning of heavily soiled items. *A large red biohazardous waste container.</p>	F 441			

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F 441	<p>Continued From page 85</p> <ul style="list-style-type: none"> *A double-sink with several shelves above it. *The shelves contained multiple clean resident use items including: <ul style="list-style-type: none"> -Emesis basins. -Plastic tubs for bed baths and resident use. -Clear plastic graduates (container used to collect urine). -Toilet seat risers. -Several small baskets. <p>Observation on 2/4/15 at 8:20 a.m. in a soiled utility room located on the southeast wing revealed:</p> <ul style="list-style-type: none"> *Two large bins filled with soiled linens. *A hopper with an attached spray hose for cleaning of heavily soiled items. *A double-sink with several shelves above it. *On the shelves were three clean plastic graduates and sitting next to them was a pink emesis basin. Inside the emesis basin was a white toothbrush that was unwrapped and unmarked. *A plastic bag containing three unwrapped and unmarked toothbrushes next to the pink emesis basin. *An ambu bag (hand-held device used to provide ventilation on a resident who is not breathing) inside of a plastic bag and a back board hanging on a wall across from the hopper. Those items were to have been clean and available for use when cardiopulmonary resuscitation (a life-saving technique) had been required for a resident. <p>Interview on 2/10/15 at 8:57 a.m. with the administrator, maintenance supervisor, DON, and infection control nurse regarding the above observations confirmed:</p> <ul style="list-style-type: none"> *They could not guarantee any of the resident-use items above would have been clean 	F 441		
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F 441	<p>Continued From page 86 due to being stored in the soiled utility room and where they were located in that room. *The DON stated "We have a storage issue in the facility." *No further comments were provided.</p> <p>3a. Observation on 2/4/15 at 8:25 a.m. of the whirlpool tub room revealed: *Two three-compartment carts one on each side of the tub. The carts contained multiple residents' care items co-mingled (mixed) together that included combs, blow dryer, incontinent products, lotions, shampoos, deodorants, single-use razors, packages of wet wipes, an unwrapped roll of toilet paper, clean hand towels, and a can of shaving cream. *A tall plastic cupboard with five shelves were multiple unmarked resident care items co-mingled together that included several bottles of lotion, shampoo, hair conditioner, deodorant, and powders. *There had been two opened boxes of bar soap that were unmarked and had used bars of soap in them. *Three of the five shelves were dirty with a dried brown dry colored substance.</p> <p>b. Observation on 2/4/15 at 9:30 a.m. of the beauty salon revealed: *Sitting on the floor was an unmarked black suitcase. The suitcase was full of permanent rods and a shower head attached to a hose. *Four window screens. *A set of wheelchair pedals. *The counter area by the sink had two wire baskets. Inside of those baskets were: -Multiple hair rollers. -Two mirrors. -Two blow-dryers.</p>	F 441			

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F 441	<p>Continued From page 87</p> <ul style="list-style-type: none"> -Two unmarked bottles of shampoo. -An unmarked tub of vaseline. -A plastic drinking glass. -A purple basket containing kleenex. -A small portable fan. -Clean hand towels. <p>c. Interview on 2/10/15 at 9:05 a.m. with the administrator, maintenance supervisor, DON, and infection control nurse regarding the above observations revealed:</p> <ul style="list-style-type: none"> *They had been unaware of all the unmarked resident care items in the tub room. *Each resident had been provided with a basket to put personal bathing supplies in. The basket was to have been brought with them on bath day. *The DON and infection control nurse would have been responsible for the over-sight of the two above mentioned rooms. *They could not confirm how often the rooms had been checked for cleanliness, appropriate storage, and marking of resident care items. <p>4. Observation and interview on 2/4/15 at 9:10 a.m. with the housekeeping supervisor revealed:</p> <ul style="list-style-type: none"> *A housekeeping closet located on the west wing. *The closet was full of chemicals and cleaning supplies. *There were five bottles of Sanotracin cleaner with expiration dates of 8/26/12. *The cleaner had been used to clean rooms exposed to highly infectious diseases if needed. *She had been unaware the cleaners were expired. *Her and the infection control nurse had been responsible for the ordering and monitoring of the chemicals used by the provider. <p>5. Observation on 2/3/15 at 10:45 a.m. of CNAs F</p>	F 441		

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F 441	<p>Continued From page 88 and J during personal care for resident 3 revealed:</p> <ul style="list-style-type: none"> *They had washed their hands and put on a clean pair of gloves. *With those gloved hands they: <ul style="list-style-type: none"> -Assisted him to stand up with a Hoyer (mechanical lift used to assist residents with standing). -Pulled down his slacks and removed his urine soiled incontinent brief. *CNA J: <ul style="list-style-type: none"> -Took several disposable wipes and cleaned resident 3's perineal area (private area). She discarded the used wipes into the trash bag. -Retrieved a tube of skin barrier cream, opened the tube, and placed some of the cream in her hand. -Rubbed the skin barrier cream onto the resident's perineal area. -Assisted CNA F to apply a clean incontinent brief and pull up his slacks. *They transferred the resident into the wheelchair, removed the Hoyer sling (used during transfer), and adjusted his legs/feet onto the foot pedals. *CNA F straightened the resident's bed covers and placed the call light within his reach. *At that time they both removed their soiled gloves and sanitized their hands. *Neither CNA F or J had removed their gloves or sanitized their hands during the entire process of assisting the resident with personal care. <p>Observation on 2/3/15 at 4:05 p.m. of CNAs C and D during personal care for resident 3 revealed:</p> <ul style="list-style-type: none"> *They washed their hands and put on a clean pair of gloves. *With those gloved hands they: 	F 441		

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

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER STRAND-KJORSVIG COMMUNITY REST HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261
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F 441	<p>Continued From page 89</p> <ul style="list-style-type: none"> -Removed a urine soaked pillow from underneath the resident. -Assisted him to sit on the edge of the bed. -Placed the Hoyer sling around resident 3 and assisted him to stand up. -Pulled down his urine soiled slacks and removed his urine soaked incontinent brief. *CNA C: <ul style="list-style-type: none"> -Retrieved wet disposable wipes and cleaned his perineal area. -Went to his closet and opened a drawer on a three compartment cart. -Retrieved a clean incontinent brief and pad from the cart and closed the drawer. *Both CNAs applied the incontinent product and pulled up his slacks. *They transferred him into his wheelchair, put on his shoes, and removed the Hoyer sling. *CNA C adjusted the bed covers and gave him the call light. *At that time they both removed their soiled gloves and sanitized their hands. *Neither CNA C or D had removed their gloves or sanitized their hands during the entire process of assisting the resident with personal care. <p>Interview on 2/10/15 at 10:30 a.m. with the infection control nurse regarding the above observations revealed:</p> <ul style="list-style-type: none"> *Personal care and handwashing had been a random audit she did all year long. *She would have provided education at the time of the observation. *She had audits supporting the above observation, but had no documentation of the education provided. *She would have expected the CNAs to remove their gloves and wash their hands when going from a dirty to clean technique. 	F 441		
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F 441	<p>Continued From page 90</p> <p>*She confirmed the technique used to provide personal care for resident 3 had not been sanitary.</p> <p>Review of the provider's undated Procedure for Incontinent/Perineal Care revealed the staff should have removed their gloves and washed their hands after assisting the resident with perineal care.</p> <p>Surveyor: 35120 Preceptor: 29354</p> <p>6. Observation on 2/3/15 at 4:10 p.m. of licensed practical nurse (LPN) A in resident 1's room revealed she:</p> <ul style="list-style-type: none"> *Without performing hand hygiene put on a pair of gloves. *Had not set-up a clean field (area). *Removed the dressing from resident 1's right heel. *Disposed of the dressing in the garbage. *Placed a box of clean supplies on the floor. *Changed her gloves. *Opened a Hydrogel (gel used to help treat skin injuries) dressing and placed the wrapper on the resident's bed. *Applied the Hydrogel dressing to resident 1's right heel. *Took a scissors from the box on the floor, cut a piece of tape, and placed the tape over the dressing. *Reached into her pocket and removed a marker. *Took the marker and wrote the date on the new dressing. *Placed the marker back in her pocket. *Removed her gloves and placed the soiled gloves on the floor. *Applied TED hose (compression stockings) to resident 1's right leg. 	F 441		

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F 441	<p>Continued From page 91</p> <p>Interview on 2/4/15 at 3:42 p.m. with the DON revealed: *LPN A should have: -Washed her hands before starting the dressing change. -Set-up a clean field for the new supplies. -Put the clean supplies on the clean field and not on the floor. -Removed her gloves before reaching into her pocket. *There was a breach of infection control during the dressing change.</p> <p>Review of the provider's undated Procedure for Clean Dressing Technique stated: **"Wash hands prior to handling clean contents of treatment cart." **"Take treatment cart to the resident's room, but not in contact with the resident or belongings. Gather and set up supplies in the resident area: -Establish clean field (can be unsterile plastic field, clean linen, etc.) not on the treatment cart. -Open supplies onto clean field, including several clean gloves. -Pour solutions into clean container, prepare ointments, medications. -Establish container for soiled dressings, supplies (plastic bag must be lower than field)." **"Wash hands (alcohol-based hand rub may be used at this point). Apply clean gloves." **"Remove old dressing and discard in the appropriate disposal bag." **"Discard soiled materials in plastic bag. Do not discard in resident's room; remove to appropriate receptacle in utility room." **"Lock and return treatment cart to appropriate storage."</p>	F 441			

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F 441	<p>Continued From page 92</p> <p>Review of the provider's April 2012 Handwashing/Hand Hygiene policy revealed:</p> <p>"All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personal, residents, and visitors."</p> <p>"Employees must wash their hands for at least fifteen seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:</p> <ul style="list-style-type: none"> -When coming on duty. -Before and after direct resident contact. -Before and after performing any invasive procedure. -Before and after assisting a resident with personal care. -Before and after changing a dressing. -Upon and after coming in contact with a resident's intact skin. -After handling soiled or used linens, dressings, bedpans, catheters, and urinals -After handling soiled equipment and utensils. -After removing gloves." <p>Surveyor: 29354</p> <p>7a. Observation on 2/3/15 at 4:20 p.m. of LPN A in resident 12's room revealed she:</p> <ul style="list-style-type: none"> *Took the nebulizer mask and disconnected it from the nebulizer machine. *Rinsed the mask with tap water. *Placed the Duoneb (medication for lung disease) medication into the mask. *Attached the mask to the nebulizer tubing and machine. *Turned the nebulizer machine on. *Told resident 12 she would be back in ten minutes. *Left the room. 	F 441		

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F 441	Continued From page 93 Observation and interview on 2/3/15 at 4:55 p.m. of CNA D revealed she: *Went into resident 12's room. *Removed the nebulizer mask from his face. *Without rinsing or disinfecting the mask placed it on resident 12's dresser. Interview at the above time with CNA D revealed she: *Was not a medication aide. *Had not rinsed or disinfected the nebulizer mask after removing it from resident 12's face. b. Observation on 2/3/15 at 5:22 p.m. of LPN A revealed she: *Went into resident 18's room. *Removed the nebulizer mask from resident 18's face. *Without rinsing the nebulizer mask placed it on top of the nebulizer machine. c. Interview on 2/10/15 at 1:45 p.m. with the DON revealed her expectations were for the staff to rinse and disinfect the nebulizer equipment after each use. Review of the provider's September 2010 Nebulizer policy revealed: **"When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece, and medication cup. *Rinse and disinfect the nebulizer equipment according to manufacturer's recommendations and facility policy. *When equipment is completely dry, store in plastic bag with the residents name and the date on it."	F 441			
F 516	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO,	F 516			

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F 516 SS=E	<p>Continued From page 94</p> <p>SAFEGUARD CLINICAL RECORDS</p> <p>A facility may not release information that is resident-identifiable to the public.</p> <p>The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>The facility must safeguard clinical record information against loss, destruction, or unauthorized use.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to store residents' medical records in a secured location. Findings include:</p> <p>1. Observation and interview on 2/10/15 at 3:45 p.m. with the director of nursing (DON) revealed she: *Went to the maintenance supervisor's room. *Used a key hanging outside of the room to unlock the door. *Went inside the room and got a second set of keys. *Went outside to a storage shed. *Used the second set of keys to unlock the storage shed. Inside the storage shed were multiple boxes of residents' medical information.</p> <p>Interview at the above time with the DON</p>	F 516	<p>F516</p> <p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></p> <p>Store residents' medical records in a secured location: The key was located in an area where only the administrator, business manager, director of nursing and maintenance manager knew the location. The key is now in the front office with access only to the administrator and business manager.</p>	3/13/2015	

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F 516	<p>Continued From page 95 revealed:</p> <ul style="list-style-type: none"> *Medical records were stored in the storage shed and in the locked filing cabinets in the basement. *She was the only one who had a key to the filing cabinets in the basement. *Staff members had access to the maintenance supervisor's room. *Staff members would have had access to the second set of keys stored in the maintenance supervisor's room. *She did not think staff members knew where the second set of keys were stored in the maintenance supervisor's room. <p>Review of the provider's June 2001 Record Retention policy revealed "All residents' records are kept in the basement for one year after discharge/death. They are then kept in the little shed."</p> <p>Review of the Long-Term Care Facilities Resident's Bill of Rights from the provider's admission packet revealed under Section 8: "You have the right to privacy and confidentiality in a long-term care facility. This includes your written and telephone communications.</p> <p>Review of the provider's updated 11/1/10 Admission Policy Agreement and Informed Consent revealed "All inquiries and information pertaining to the resident and prospective resident's will be kept in strict confidence."</p>	F 516		
F 520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and</p>	F 520	<p>F520 <u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement</u></p>	3/13/2015

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F 520	<p>Continued From page 96</p> <p>assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, job description review, and policy review, the provider failed to ensure an effective quality assurance (QA) program had been maintained to identify concerns and to develop and implement corrective actions. Findings include:</p> <p>1. Interview on 2/10/15 at 10:00 a.m. with the QA registered nurse (RN) confirmed: *She was responsible for the QA program. *Staff who attended the QA committee meeting had been the administrator, director of nursing (DON), all the department managers, the medical</p>	F 520	<p><u>with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></p> <p>Staff education for all staff was provided on 3/4/15 at the all staff inservice training regarding the QAPI committee, who is involved and the purpose of the QAPI committee. The physician will be informed of the meetings scheduled on a quarterly basis. If the physician is unable to attend the meeting, the minutes of the meeting will be sent requesting his signature. This change was reviewed with the staff at the inservice and will then be monitored by the administrator and the DON quarterly.</p>	
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F 520	<p>Continued From page 97</p> <p>director, and restorative aides/certified nursing assistants.</p> <p>*The medical director had attended the 4/2/14, 7/15/14, and 1/5/15 QA meetings. The medical director had not attended the 11/18/14 QA meeting. They had informed the medical director of the meeting, but there was no documentation related to that.</p> <p>*The QA committee met monthly.</p> <p>*They had done random audits on residents' personal care, dressing changes, and handwashing.</p> <p>*They would copy policies and leave the policies for the staff to read.</p> <p>*They used "root-cause" (a tool used to identify the most basic cause of a problem) analysis for identifying problem areas. She was unable to give an example of an area they had been working on.</p> <p>*All staff were encouraged to bring ideas to the QA committee.</p> <p>*All staff were aware of the QA committee.</p> <p>*They had initiated the Performance Improvement Program (PIP) that included residents and family. They had only met once with the PIP representatives.</p> <p>Further interview on 2/10/15 at 10:50 a.m. with the QA RN regarding the following issues confirmed:</p> <p>*There had been a breach in infection control with:</p> <ul style="list-style-type: none"> -Cleaning of the nebulizer. -Dressing change done. -Hand washing. <p>*New nurses had not administered medications according to professional standards.</p> <p>*The medical director had not consistently attended the quarterly QA meetings.</p>	F 520			

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F 520	<p>Continued From page 98</p> <p>Interview on 2/10/15 at 1:45 p.m. with the DON confirmed she:</p> <ul style="list-style-type: none"> *Was part of the QA committee. *Agreed there were problems with infection control practices and with medication administration. *Had not had time to observe the new staff, because she had been working on the floor for the past three months. <p>Review of the provider's 12/2/13 Quality Assurance Performance Improvement policy revealed the committee:</p> <ul style="list-style-type: none"> *"Must meet at least monthly to identify issues with respect to quality assessment and assurance. *Is to develop and implement appropriate plans of action and to correct identified quality deficiencies. *Uses good faith attempts to identify and correct quality deficiencies. *Will use root cause analysis to probe quality deficiencies. *Will utilize the PDSA (Plan, Do Study, Act) approach to process improvement. *Incorporates PIP teams when needed." <p>Review of the provider's undated Quality Assessment and Assurance Coordinator Job Description revealed "The primary purpose of your job position is to plan, organize, develop, coordinate, and direct the Quality Assessment and Assurance Program in accordance with current applicable federal, state, and local standards, guidelines and regulations, as may be directed by the administrator, to assure that the highest degree of quality resident care and safety can be maintained at all times."</p>	F 520			

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F 520	<p>Continued From page 99 Surveyor: 35120 Preceptor: 29354</p> <p>2. Interview on 2/10/15 at 11:15 a.m. with the laundry supervisor revealed he: *Had not been sure if the provider had a QA program but thought they did. *Thought he would talk to the Minimum Data Set coordinator about it if he had questions about QA.</p> <p>Interview on 2/10/15 at 11:23 a.m. with certified nursing assistant/medication aide J revealed she: *Thought there had been a QA program but had not been for sure if there was one. *Thought she would have talked with the DON if she had questions about QA.</p> <p>3. Refer to F156, F159, F167, F248, F253, F279, F280, F281, F309, F314, F323, F329, F332, F353, F356, F371, F428, F441, and F514.</p>	F 520		

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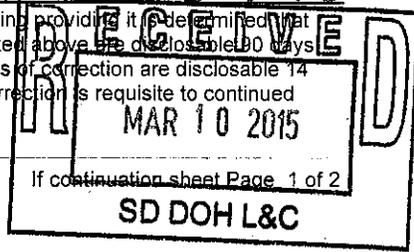
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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/4/15. Strand-Kjorsvig Community Rest Home was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 2/4/15. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 028 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers provide a minimum clear width of 32 inches (81cm) for swinging or horizontal doors. Vision panels are of fire-rated glazing or wired glass panels and steel frames. 19.3.7.5, 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain clear door widths of at least 32 inches in the cross-corridor smoke barriers in both the east and west corridors. Findings include:	K 028		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shannon Schmidt</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3-8-15</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 30 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 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.



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

PRINTED: 02/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435125	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2015
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NAME OF PROVIDER OR SUPPLIER STRAND-KJORSVIG COMMUNITY REST HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261
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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 028	<p>Continued From page 1</p> <p>1. Observation at 10:00 a.m. on 2/4/15 revealed the cross-corridor doors in the east and west wing corridors were only 32 inches wide and did not provide a clear opening width of 32 inches. Review of the previous survey report revealed those doors were the original doors.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.</p>	K 028		
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10673	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2015
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NAME OF PROVIDER OR SUPPLIER
STRAND-KJORSVIG COMMUNITY REST HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
**801 S MAIN POST OFFICE BOX 195
ROSLYN, SD 57261**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/3/15 through 2/5/15 and from 2/10/15 through 2/11/15. Strand-Kjorsvig Community Rest Home was found not in compliance with the following requirements: S210 and S236.	S 000		
S 210	44:04:04:06 EMPLOYEE HEALTH PROGRAM The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18560 Based on employee file review, interview, and policy review, the provider failed to ensure five of five newly hired employees (A, D, F, K, and L) were evaluated by a licensed health professional	S 210	S210 All new employees will have health evaluations done by the DON or MDS coordinator within fourteen days of employment. This will be monitored by the administrator and QAPI committee quarterly. All new employees have been evaluated. A policy was created and implemented immediately on 3/6/15 regarding whether the employee has any communicable diseases. For all new employees, a general physical assessment will be done by the RN and dated. The results of this follow up report will be noted and	3/15/2015

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

TITLE

(X6) DATE

Shannon Schmidt

Administrator

3-8-15

STATE FORM

6899 O2UI11

Continuation Sheet 1 of 4

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10673	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2015
NAME OF PROVIDER OR SUPPLIER STRAND-KJORSVIG COMMUNITY REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 210	<p>Continued From page 1</p> <p>for freedom from reportable communicable diseases. Findings include:</p> <p>1. Review of employee files revealed: *Employee F had been hired on 10/2/14. She had completed and signed the employee health questionnaire on 10/8/14. *Employee K had been hired on 11/13/14. She had completed and signed the employee health questionnaire on 11/13/14. *Employee L had been hired on 11/28/14. She had completed and signed the employee health questionnaire on 9/13/12. *Employee D had been rehired on 12/30/14. She had completed and signed the employee health questionnaire on 3/26/14. The questionnaire had been signed by the director of nursing (DON) on 3/26/14. *Employee A had been hired on 1/8/15. She had completed and signed the employee health questionnaire on 1/14/15. *The above questionnaires had not been signed by a licensed health professional stating they were free from reportable communicable disease. Review of the provider's employee health questionnaire revealed no documented area for a licensed health professional to review the information provided and verify the employee was free from reportable communicable diseases.</p> <p>Interview on 2/10/15 at 10:45 a.m. with the DON confirmed the employee health questionnaire had not included documentation the information provided by the employee had been reviewed by a licensed health professional. The questionnaire had not included a statement the employee was free from reportable communicable diseases.</p> <p>Review of the provider's undated Infection Prevention and Control Employee Health policy</p>	S 210	<p>observed by the DON and administrator quarterly. The information of their findings will go to the QAPI committee meeting on a quarterly basis and will be reported by the DON and administrator.</p>	

South Dakota Department of Health

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NAME OF PROVIDER OR SUPPLIER STRAND-KJORSVIG COMMUNITY REST HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261
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S 210	Continued From page 2 revealed it was the policy of the facility to prohibit employees with communicable disease to have direct contact with residents.	S 210		
S 236	<p>44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS</p> <p>Tuberculin screening requirements for healthcare workers or residents are as follows:</p> <p>(1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18560 Based on employee file review, interview, and policy review, the provider failed to ensure three of five newly hired employees (A, K, and L) reviewed had completed the two-step method of Mantoux skin test for tuberculin (TB) screening within fourteen days of employment. Findings include:</p>	S 236	<p>S236</p> <ol style="list-style-type: none"> 1. Proper tuberculin screenings should be completed at all times. All residents and staff are potentially at risk for improper tuberculin screenings. 2. The facility Director of Nursing educated all department managers and charge nurses on proper tuberculin screening procedures on 3/4/15 at the all staff inservice training. 3. The facility Director of Nursing will complete written audits a minimum of 1 time per week X 4 weeks, then monthly X 3 months on proper tuberculin procedures. Results of her review will be reported to the QAPI committee that meets each month until the QAPI 	3/15/2015

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10673	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2015
NAME OF PROVIDER OR SUPPLIER STRAND-KJORSVIG COMMUNITY REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 236	<p>Continued From page 3</p> <p>1. Review of employee files revealed: *Employee K had been hired on 11/13/14. Her TB first-step had been administered on 11/14/14. Her TB second-step had been administered on 12/12/14. *Employee L had been hired on 11/28/14. She had documentation of a TB first-step within the past year. There was no documentation the TB second-step had been administered. *Employee A had been hired on 1/8/15. Her TB first-step had been administered on 1/12/15. There was no documentation the TB second-step had been administered.</p> <p>Interview on 2/10/15 at 10:40 a.m. with the director of nursing revealed she thought only the TB first-step needed to be completed within fourteen days of employment.</p> <p>Review of the provider's January 2008 TB Screening policy revealed all new employees would be tested for TB using the Mantoux two-step testing method. The policy had not stated the testing had to be completed within fourteen days of employment.</p>	S 236	committee advises to discontinue.	