

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

**ORIGINAL**

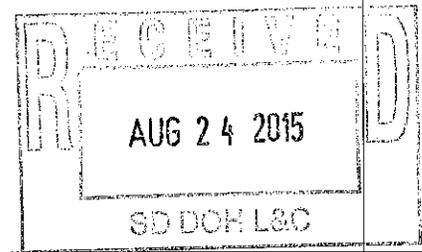
PRINTED: 07/27/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/15/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TEKAKWITHA NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6 E CHESTNUT SISSETON, SD 57262</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  Surveyor: 33488 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/13/15 through 7/15/15. Tekakwitha Nursing Center was found not in compliance with the following requirement(s): F157, F221, F280, F281, F329, F371, F431, F441, and F456.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	F 157 Obtained Physicians order for treatment of pressure ulcer and updated care plan on July 14, 2015 for resident 1. We updated policy with specifications on notification of physician. Will implement physician log form and educate nursing staff of changes on August 7, 2015. We will implement a physician contact log for all changes in condition of residents. The DON will monitor the contact log to ensure <sup>24 hour</sup> notification of physician for ninety days and findings will be brought to the QA meetings quarterly.	9/1/15 <i>al</i> 8/21/15



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>James Cantor</i>	TITLE Administrator	(X6) DATE 8/5/15
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting, providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on record review, interview, and policy review, the provider failed to ensure the physician was notified of a pressure ulcer (injury to the skin) for one of one sampled resident (1). Findings include:</p> <p>1. Review of resident 1's medical record revealed: *A re-admission date of 4/18/12. *Diagnoses of multiple sclerosis (disease causing damage to the nerves resulting in decrease in body functions and capabilities), depression (sadness), and lack of coordination. *She could not move her legs on her own. *She had been dependent upon the staff for transfers, bed mobility (moving and changing position when in bed), dressing, and personal hygiene. *She had a history of pressure ulcers.</p> <p>Review of resident 1's 7/8/15 through 7/13/15 nursing progress notes revealed: *7/8/15 "Note pressure ulcer to coccyx [area surrounding the tailbone], area assessed and measured, see observations. Referral form sent to AMT [American Medical Technologies] wound care nurse awaiting recommendation and will then forward to primary MD [medical doctor]." *7/11/15 "(MDs name) here for monthly rounds no new orders noted."</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>*No further nursing documentation had been found to support:</p> <ul style="list-style-type: none"> <li>-The physician had been informed of the pressure ulcer to the resident's coccyx.</li> <li>-The wound nurse had been in contact with the nursing staff for further recommendations.</li> </ul> <p>Review of resident 1's 7/11/15 physician's orders revealed no documentation to support he/she was notified by the nursing staff of the new pressure ulcer on the resident's coccyx.</p> <p>Interview on 7/14/15 at 3:10 p.m. with the Minimum Data Set (MDS) assessment coordinator regarding resident 1 revealed:</p> <ul style="list-style-type: none"> <li>*She had been aware of the pressure ulcer to the resident's coccyx.</li> <li>*The staff had been applying a protective ointment to the wound until orders were received from the physician.</li> <li>*She had been the one who faxed the wound care nurse for treatment recommendations.</li> <li>*On 7/10/15 she had: <ul style="list-style-type: none"> <li>-Received a treatment recommendation from the wound nurse.</li> <li>-Attempted to contact the physician with those recommendations by fax.</li> </ul> </li> <li>*She had: <ul style="list-style-type: none"> <li>-Attempted to call the physician's office for orders and re-faxed the wound nurse's recommendations on 7/14/15.</li> <li>-Not received any orders from the physician at this time.</li> <li>-Not documented on 7/10/15 or 7/14/15 in the resident's chart any involvement with the wound nurse or attempts to contact the physician. She agreed she should have.</li> <li>-Provided documentation of a faxed recommendation by the wound nurse on 7/10/15.</li> </ul> </li> </ul>	F 157		

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F 157	Continued From page 3 -Provided two faxed forms to the physician with both of them dated 7/14/15. One of the forms was stamped revealing it had been sent on 7/10/15. -Not confirmed any attempts to contact the physician prior to 7/10/15 or between 7/10/15 through 7/14/15. -Expected the nursing staff to have informed the physician of the pressure ulcer on 7/11/15 during her/his monthly consultation with the resident. *She agreed the physician had not been informed of the wound in a timely manner. *She agreed there was no documentation to support the physician had been notified of the pressure ulcer until 7/14/15.  Interview on 7/15/15 at 2:00 p.m. with the director of nursing (DON) revealed she: *Had been aware of the pressure ulcer to resident 1's coccyx. *Was not aware there had not been a treatment order received by the physician. *Agreed there should have been documentation in the resident's chart to support any involvement with the wound nurse. *Agreed there should have been documentation to support the attempts to contact the physician from 7/8/15 through 7/14/15. *Agreed the physician had not been informed of the wound in a timely manner.  Review of the provider's undated Change in a Resident's Condition or Status policy revealed "The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been a need to alter the resident's medical treatment significantly."	F 157	F221 On August 6, 2015, All Staff were in-serviced on the proper assessing of restraints and side rail use. MDS Nurse will do an assessment upon admission and quarterly thereafter. A side rail assessment was done on resident #8 and plan of care updated to include use of side rails for bed mobility.. Resident #1 care plan was updated on July 14, 2015. Resident #10 care plan was updated to include use of side rails for bed mobility. A trial removal of lap buddy was completed 8-1 to 8-4-15 for resident #10 and it was determined the lap buddy was not necessary. The order was discontinued on 8-4-15. Resident #11 side rail assessment was completed on 8/4/15 and care plan was updated to include use of side rails for bed mobility. Education was given to nursing staff on importance of proper documentation on August 6, 2015. Physician's orders for any restraint will include the purpose	
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS	F 221		8/10/15

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F 221	Continued From page 4  The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.  This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure assistive devices that had the potential to be a restraint for four of six sampled residents (1, 8, 10, and 11) were appropriately assessed, documented on, and care planned to ensure appropriate use. Findings include:  1. Observation of resident 1's bed from 7/13/15 through 7/14/15 revealed there had been two one-quarter side rails up on the top half of both sides of her bed.  Interview on 7/13/15 at 3:20 p.m. with resident 1 confirmed she had used the side rails to help the staff reposition her in bed.  Review of resident 1's medical record revealed: *There had been no physician's order for the use of side rails. *There had been a side rail assessment completed on 6/3/15. *Her care plan had not identified the use of those side rails.  2. Observation on 7/15/15 at 10:10 a.m. of resident 10's room revealed: *There had been two one-quarter side rails up on the top half of both sides of his bed.	F 221	the restraint use. A physicians order will be obtained for use of top side rails, if determined they are a restraint, then it will be assessed per restraint protocol. The comprehensive care plan and policy were updated August 4, 2015. IDT will evaluate each resident utilizing physical restraint's weekly. The DON will monitor the medical record of all new admissions to ensure completion of side rail assessments for ninety days and results brought to the QA meetings quarterly. <i>for one year.</i>  Addendum: The siderail assessment does include sharing the risks and benefits with the residnet and family.		

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F 221	<p>Continued From page 5</p> <p>*The resident had not been laying in his bed.</p> <p>Review of resident 10's medical record revealed: *An admission date of 10/14/05. *Multiple mental diagnoses with increase in confusion and psychosis (loss of reality), history of falls, and muscle weakness. *There had been no physician's order for the use of side rails. *There had been a side rail assessment completed 6/30/15. *His care plan had not identified the use of those side rails. *On 4/30/15 the physician had ordered a lap buddy (soft cushion put across mid-section) to be in place when the resident was in his wheelchair (w/c).</p> <p>Random observations of resident 10 from 7/13/15 through 7/15/15 revealed: *He had been sitting in his w/c. *There had been a lap buddy placed over his lap and secured in place by the w/c arms. *The cushion had been removed during meals.</p> <p>Interview on 7/15/15 at 9:27 a.m. with registered nurse (RN) D and certified nursing assistant (CNA) F regarding resident 10 revealed: *The resident had required the use of a lap buddy in his w/c to assist him with positioning. He had a history of poor positioning and would lean forward in his w/c. *He had been using the lap buddy for about a couple of months. *He was able to remove the lap buddy on his own.</p> <p>Observation and interview on 7/15/15 at 10:55 a.m. with resident 10 revealed:</p>	F 221		

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F 221	<p>Continued From page 6</p> <p>*He stated "yes" when the surveyor asked if he could remove the lap buddy.</p> <p>*When the surveyor asked the resident to show her how he could remove the lap buddy, he did so without difficulty.</p> <p>Review of resident 10's progress notes from 4/19/15 through 7/14/15 revealed:</p> <p>*There had been random documentation to support the use of a lap buddy when he was in his w/c.</p> <p>*The documentation revealed he had used the lap buddy for safety.</p> <p>*No documentation to support:</p> <p>-What that safety issue was.</p> <p>-The lap buddy had been used to assist him with positioning while sitting up in his w/c.</p> <p>-Why the physician had ordered the use of a lap buddy to be used in his w/c on 4/30/15.</p> <p>Review of resident 10's 6/30/15 restraint assessment revealed:</p> <p>*No documentation to support:</p> <p>-The purpose and medical symptom for the continued use of a lap buddy.</p> <p>-There had not been an attempt to not use the lap buddy since 4/30/15.</p> <p>-The resident could remove the lap buddy on his own.</p> <p>3. Observation of resident 11 on 7/15/15 at 9:40 a.m. revealed he had been laying in his bed with one-quarter side rails up on the top half of both sides of his bed.</p> <p>Review of resident 11's medical record revealed:</p> <p>*An admission date of 5/6/15.</p> <p>*Diagnoses of muscle weakness, depression, anxiety (anxiousness), epilepsy (uncontrolled</p>	F 221			

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F 221	<p>Continued From page 7</p> <p>body movements), congestive heart failure (poor function of the heart), and history of pneumonia (infection in the lungs).</p> <p>*There had been no physician's order for the use of the side rails.</p> <p>*There had not been a side rail assessment completed for him.</p> <p>*His care plan had not identified the use of those side rails.</p> <p>*He had increased confusion and anxiety upon his admission.</p> <p>Review of resident 11's progress notes from 5/6/15 through 7/14/15 revealed:</p> <p>*On 5/13/15:</p> <p>-He had been very anxious and made several attempts to put himself on the floor when the staff did not assist him.</p> <p>-The nursing staff had notified the physician, and a lap buddy was ordered to be used when the resident had been in his w/c to "prevent sliding out of chair."</p> <p>*On 5/14/15 "Lap buddy on while up in wheelchair."</p> <p>*On 5/15/15 "Lap buddy in place for positioning."</p> <p>*On 5/20/15 "Lap buddy in place."</p> <p>*No documentation to support the lap buddy had been used after 5/20/15.</p> <p>Review of resident 11's July 2015 daily CNA charting revealed:</p> <p>*He had been wearing the lap buddy when he was in his w/c.</p> <p>*They had removed the lap buddy every two hours and as needed.</p> <p>*There had been no indication the use of the lap buddy had been discontinued.</p> <p>Interview on 7/15/15 at 9:30 a.m. with RN D and</p>	F 221		

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F 221	<p>Continued From page 8</p> <p>CNA F revealed they had not been sure if resident 11 still required the use of a lap buddy.</p> <p>There had been no restraint assessment completed for resident 10 until 6/2/15 to support the appropriate use of a lap buddy. The restraint assessment had not identified the purpose nor the duration of use for the lap buddy.</p> <p>Random observations of resident 11 from 7/13/15 through 7/15/15 revealed when he was in his w/c there was no lap buddy in place.</p> <p>Interview on 7/15/15 at 2:05 p.m. with the director of nursing (DON) and Minimum Data Set (MDS) assessment coordinator confirmed:</p> <ul style="list-style-type: none"> <li>*The use of the side rails should have been documented on the care plans for residents 1, 10, and 11.</li> <li>*Resident 11 should have had: <ul style="list-style-type: none"> <li>-A side rail assessment completed.</li> <li>-A physician's order to support the use of the side rails.</li> <li>-An intervention in place on his care plan.</li> </ul> </li> <li>*Resident 11: <ul style="list-style-type: none"> <li>-Had been using a lap buddy for safety upon admission.</li> <li>-Had not required the use of a lap buddy since the physician had adjusted some of his medications.</li> <li>-The lap buddy should have been discontinued. They had not been aware the nursing staff had not discontinued the use of a lap buddy.</li> <li>-The restraint assessment on him had not been completed in a timely manner.</li> </ul> </li> <li>*The restraint assessments for residents 10 and 11 should have supported an appropriate reason and use for the lap buddies.</li> </ul>	F 221		

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F 221	<p>Continued From page 9</p> <p>Surveyor: 26180</p> <p>4. Observation of resident 8 on 7/13/15 at 6:30 p.m. and at random times throughout 7/14/15 and 7/15/15 revealed she was laying in her bed with one-quarter side rails up on the top half of both sides of her bed.</p> <p>Review of resident 8's entire medical record revealed: *She had dementia and was confused. *There had not been a side rail assessment completed on her. *Her care plan had not addressed a side rail being used.</p> <p>Interview on 7/15/15 at 3:00 p.m. with the director of nursing and the MDS coordinator revealed a side rail assessment had not been completed on resident 8.</p> <p>5. Review of the provider's undated Side Rail policy revealed: *"Side rails will not be used as a restraint to prevent the resident from getting out of bed." *"A physician's order will be obtained for use of all side rails."</p> <p>Review of the provider's 3/27/15 Restraints - Physical policy revealed: *Definition "Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." *"A resident has the right to be free from any physical restraint imposed for purposes of discipline or convenience and is not required to</p>	F 221		

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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	
F 221	Continued From page 10 treat a medical symptom." *"Physical restraint use will be utilized only when the resident has medical symptoms that warrant their use and/or for positional needs to maintain proper body alignment." *"It is assumed on admission to the facility that the resident does not require any type of physical device support (including side rails) until the assessment indicates otherwise."	F 221			
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review,	F 280	F 280 Obtained Physicians order for treatment of pressure ulcer and updated care plan on July 14, 2015 for resident #1. We updated policy with specifications on notification of physician. Will implement physician log form and educate nursing staff of changes on August 7, 2015. Resident #10 care plan was updated to include use of side rails for bed mobility. A trial removal of lap buddy was completed 8-1 to 8-4-15 for resident #10 and it was determined the lap buddy was not necessary. The order was discontinued on 8-4-15. Resident #11 side rail assessment was completed on 8/4/15 and care plan was updated to include use of side rails for bed mobility. Resident #6 care plan was updated with possible side effects related to antidepressant use. Also, will update with approaches and interventions	8/10/15	

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F 280	<p>Continued From page 11</p> <p>and policy review, the provider failed to ensure 7 of 13 sampled residents' (1, 2, 6, 7, 8, 10, and 11) care plans had been reviewed and revised to reflect the resident's individual needs. Findings include:</p> <p>1. Review of resident 1's medical record revealed: *A re-admission date of 4/18/12. *Diagnoses of multiple sclerosis (disease causing damage to the nerves resulting in decrease in body functions and capabilities), depression (sadness), and lack of coordination. *She could not move her legs on her own. *She had been dependent upon the staff for transfers, bed mobility, dressing, and personal hygiene. *She had a history of pressure ulcers (wound) and currently had a stage II (wound from constant pressure) pressure ulcer to her coccyx (tailbone area).</p> <p>Review of resident 1's 5/25/15 quarterly Minimum Data Set assessment (MDS) revealed: *She had been at risk for pressure ulcers. *She required a turning and repositioning program. *She had been chairfast with changing of positions and body movements were very limited.</p> <p>Review of resident 1's 6/11/15 care plan revealed: *On 7/18/15: -Problem: "Resident has pressure ulcer to coccyx." -Goal: "Resident's ulcer will heal without complications." *Approach: "Complete treatment as ordered when referral approved by the MD [medical doctor]. Report signs of infection. Weekly</p>	F 280	<p>for meal refusal and self removal of catheter.</p> <p>Resident #7 care plan was updated to be more specific in addressing outings to café and daily whirlpool bath.</p> <p>Resident #2 care plan was updated to include monitoring and documentation of fluid intake and education of resident. NOC nurse will be responsible for calculating 24 intakes and recording. Fax monthly intakes to KD unit and MD. 3 months.</p> <p>Resident #8 care plan was updated to address pelvic fracture, catheter use and indication for use, pain management, weight loss with need to be fed, and use of side rails.</p> <p>IDT will audit each resident's care plan during the quarterly MDS assessment period with the checklist (one year) referred to in the policy and procedure. DON will monitor weekly compliance of departments recording intakes for 90 days and report findings to QA.</p>	<p><i>g</i> <i>8/21/15</i></p>
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F 280	<p>Continued From page 12</p> <p>measuring and assessment of ulcer. Follow-up with wound nurse as needed [prn]."</p> <p>*No documentation to support:</p> <ul style="list-style-type: none"> <li>-Prior to 7/18/15 that she had been at risk for skin breakdown.</li> <li>-What her turning and repositioning program consisted of.</li> <li>-What further preventative measures should have been in place for her bed and wheelchair.</li> </ul> <p>2. Observation on 7/15/15 at 10:10 a.m. of resident 10's room revealed:</p> <ul style="list-style-type: none"> <li>*The had been two one-quarter side rails up on the top half of both sides of his bed.</li> <li>*The resident had not been laying in his bed.</li> </ul> <p>Review of resident 10's medical record revealed:</p> <ul style="list-style-type: none"> <li>*An admission date of 10/14/05.</li> <li>*Multiple mental diagnoses with increase in confusion and psychosis (loss of reality), history of falls, and muscle weakness.</li> <li>*There had been no physician's order for the use of side rails.</li> <li>*There had been a side rail assessment completed on 6/30/15.</li> <li>*His care plan had not identified the use of those side rails.</li> </ul> <p>3. Observation of resident 11 on 7/15/15 at 9:40 a.m. revealed he had been laying in his bed with one-quarter (1/4) side rails up on the top half of both sides of his bed.</p> <p>Review of resident 11's medical record revealed:</p> <ul style="list-style-type: none"> <li>*An admission date of 5/6/15.</li> <li>*Diagnoses of muscle weakness, depression, anxiety (anxiousness), epilepsy (uncontrolled body movements), congestive heart failure (poor function of the heart), and history of pneumonia</li> </ul>	F 280			

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F 280	<p>Continued From page 13 (infection in the lungs). *There had been no physician's order for the use of the side rails. *There had not been a side rail assessment completed for him. *His care plan had not identified the use of those side rails.</p> <p>4. Interview on 7/15/15 at 2:05 p.m. with the director of nursing (DON) and MDS coordinator confirmed: *Resident 1's care plan should have identified her risk of skin breakdown and interventions for the staff to follow. *The use of the side rails should have been documented on the care plans. *The interdisciplinary care team and nursing staff had been responsible for the reviewing and revising of the care plans. *They agreed all of the above areas of concern for residents 1, 10, and 11 should have found on their care plans. *Their care plans had not reflected the current level of care they had required.</p> <p>Surveyor: 33488 5. Review of resident 6's current electronic care plan printed on 7/13/15 revealed: *He was on Celexa (antidepressant). *The approach section was not specific in what side effects of the medication that were to be monitored. *He was known to refuse to eat meals. *The approach listed was to offer cereal with milk if he refused his meal. *There was no mention of monitoring for weight loss, food preferences, supplements, or what to do if he refused the cereal and milk.</p>	F 280		

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F 280	<p>Continued From page 14</p> <p>*He had a history of pulling out his urinary catheter (tube inserted into the bladder). *The approach was to provide one-to-one staff as needed. *There was no specifics on how to prevent the resident from trying to pull his catheter out or how long supervision would be needed with the one-to-one.</p> <p>6. Review of resident 7's current electronic care plan, printed on 7/13/15 revealed: *There was no mention of the resident's daily outing to the cafe downtown. *There was no mention of the daily whirlpool bath the resident was to have.</p> <p>Interview on 7/15/15 at 3:15 p.m. with the director of nursing and the MDS coordinator revealed they agreed the above care plans were not specific to the areas of concern for residents 6 and 7.</p> <p>Surveyor: 26180</p> <p>7. Review of resident 2's 1/17/15 physician's order revealed "Diet: Dialysis (treatment for loss of kidney function) diet, NCS [no concentrated sweets.] No orange juice or bananas. Special instructions: 1000 ccs [cubic centimeters] fluid restrictions."</p> <p>Interview on 7/14/15 at 10:00 a.m. of resident 2 revealed she was alert and oriented to person, place and time. She was able to make her own decisions.</p> <p>Interview on 7/15/15 at 2:00 p.m. with the certified dietary manager (CDM) regarding resident 2 revealed:</p>	F 280		

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F 280	<p>Continued From page 15</p> <p>*The resident refused any interventions or teaching regarding her diet restrictions.</p> <p>*She would voice she understood but then would go out and buy all sorts of soda and other food and candy she should not have had.</p> <p>-"She drinks 12 pack after 12 pack of pop."</p> <p>*Sometimes she cannot complete her dialysis, because she has so much fluid in her.</p> <p>*The dietary department gave her four ounces (oz) of juice and milk at breakfast, and four (oz) of fluid at the noon and supper meals.</p> <p>-They no longer had dietary cards with instructions on them.</p> <p>-The CDM told her staff how much fluid she was supposed to get.</p> <p>-She agreed relying only on telling staff what to give her might have been not the best approach.</p> <p>*She drank so much in her room, and sometimes the certified nursing assistants would give her glasses of water to drink.</p> <p>-She had told them not to do that.</p> <p>-She thought they needed more education on that.</p> <p>*She doubted the intake records were accurate when it said she only had 500 ccs, because she drank all the time.</p> <p>Interview on 7/15/15 a 2:50 p.m. with the director of nurses regarding resident 2 revealed:</p> <p>*She confirmed the above interview with the CDM regarding the noncompliance of the resident.</p> <p>*They probably had not kept track of everything she drank.</p> <p>*She agreed they would not have been following physician's orders for fluid restrictions if they had not been monitoring her fluids.</p> <p>Review of resident 2's 1/23/12 care plan revealed:</p>	F 280		

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F 280	<p>Continued From page 16</p> <ul style="list-style-type: none"> <li>*She had a diagnosis of diabetes (unable to control blood sugars).</li> <li>*Was on kidney dialysis 3x (three times) per week related to renal failure.</li> <li>*Staff were to restrict intake of fluids to 1000 cc/day.</li> <li>-It had not specified how the restriction of fluids was to have occurred:             <ul style="list-style-type: none"> <li>-Through the dietary department.</li> <li>-At food related activities.</li> <li>-By the nursing department.</li> <li>-When she returned from outings.</li> <li>-With family involvement.</li> <li>-With fluids in her room.</li> </ul> </li> </ul> <p>8. Interview with RN D on 7/14/15 at 7:30 a.m. and at 4:00 p.m. regarding resident 8 revealed:</p> <ul style="list-style-type: none"> <li>*She had fallen twice in the past month.</li> <li>-The second fall resulted in a fractured pelvis.</li> <li>*She had a lot of pain from the fracture.</li> <li>*They had inserted the catheter, because it had been painful for her to transfer and go to the bathroom.</li> <li>*She had also had problems with urinary retention (unable to empty the bladder).</li> <li>*She was confused and unable to communicate verbally if she had pain.</li> <li>-She would not ask for medication for pain.</li> <li>*Her appetite was very poor since the fall.</li> <li>*She had recently moved to a different wing because her care needs had changed.</li> <li>*Her family had requested she stay in bed and just be kept comfortable.</li> <li>*She required the extensive assistance of two staff for repositioning in bed.</li> <li>-She could turn better to the left than the right.</li> </ul> <p>Random observations of resident 8 from 7/13/15 through 7/15/15 revealed:</p>	F 280		

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F 280	<p>Continued From page 17</p> <p>*After supper on 7/13/15 she was laying in her bed with the side rails up on both sides of her upper bed.</p> <p>*She came out to the dining room for breakfast on 7/14/15.</p> <p>*She attempted to shift her body in the wheelchair, and appeared to be uncomfortable.</p> <p>*After breakfast she remained in bed the rest of the day.</p> <p>*She was fed all of her meals.</p> <p>Review of resident 8's entire medical record revealed:</p> <p>*She had fallen on 6/25/15 and fractured her pelvis.</p> <p>*On 7/13/15 the DM had documented "___ [name of resident] has lost 12 pounds in less than 1 month since fall. She complains of a lot of pain and doesn't want to eat. Drinking 2 oz [ounce] resource {a nutritional supplement} + [plus] TID [three times a day] with meals with request to have TID at snack time also."</p> <p>*Her physician had ordered both scheduled and as needed medications to keep her comfortable and manage the pain.</p> <p>Interview on 7/14/15 at 4:00 p.m. with certified nursing assistant (CNA) G regarding resident 8 revealed:</p> <p>*He had not worked with her since she had fallen and had moved to the north wing.</p> <p>*They referred to the CNA care book to learn about a resident's care needs.</p> <p>*He was currently unable to find the care sheet on resident 8 that he was referring to, but showed the surveyor the daily assignment sheet.</p> <p>Interview on 7/14/15 at 4:05 p.m. with CNA H revealed she:</p>	F 280		

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F 280	<p>Continued From page 18</p> <p>*Had been employed at the facility for one month. *Was working with CNA G on the wing where resident 8 resided. *Was unsure if resident 8 had a fractured hip or pelvis. *Would have to know if resident 8 had pain before she transferred her. *Would also refer to the CNA care book to learn about a resident's care needs but was unable to find the information she needed.</p> <p>Review of the 7/14/15 daily assignment sheet revealed resident 8 "has a cath [catheter], take dentures out at HS [hour sleep] Mech [mechanical] soft diet."</p> <p>Review of resident 8's 7/10/15 care plan revealed: *Problem: "Resident requires an indwelling catheter." *It had not addressed: -The pelvis fracture. -The catheter had been placed due to pain with movement. -The urinary retention. -Her weight loss. -How her pain was managed for her. -Her need to have been fed. -The use of side rails on her bed.</p> <p>9. Review of the provider's undated Care Plans policy revealed: *"An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. *Assessments of residents are ongoing and care plans are revised as information about the</p>	F 280		

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F 280	Continued From page 19 resident and the resident's condition change. *The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: -a. When there has been a significant change in the resident's condition; -b. When the desired outcome is not met. -c. When the resident has been readmitted to the facility from a hospital stay; and -d. At least quarterly."	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, policy review, and professional standard review, the provider failed to ensure physician's orders were followed regarding fluid restriction for one of one sampled resident (2). Findings include:  1. Review of resident 2's 1/17/15 physician's order revealed "Diet: Dialysis diet, NCS [no concentrated sweets]. No orange juice or bananas. Special instructions: 1000 ccs [cubic centimeters] fluid restrictions."  Review of resident 2's fluid intake record from 6/14/15 through 7/13/15 revealed: *There were nine days there was nothing recorded for fluid intake. *Of the twenty-one days that were recorded, five of those days had less than 500 ccs of fluid.	F 281  <i>nursing</i>  <i>8/17/15</i>	F 281  Resident #2 care plan was updated to include monitoring and documentation of fluid intake and education of resident. NOC nurse will be responsible for calculating 24 hour intakes and recording. Fax monthly intakes to KD unit and MD. (3 months) IDT will audit resident's care plan during the quarterly MDS assessment period with the checklist referred to in the policy and procedure. DON will monitor weekly compliance of departments recording intakes for 90 days and report findings to QA.  <i>8/17/15</i>	8/17/15	

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F 281	<p>Continued From page 20</p> <p>Review of resident 2's 1/23/12 care plan revealed: *She had a diagnosis of diabetes (unable to control blood sugar levels). *Was on kidney dialysis 3x (three times] per week related to renal failure. *Staff were to restrict intake of fluids to 1000 cc/day.</p> <p>Interview on 6/14/15 at 3:00 p.m. with registered nurse A revealed there might have been days when no fluid was documented, because the resident might have been out of the facility or "human error."</p> <p>Interview on 7/15/15 at 2:00 p.m. with the certified dietary manager (CDM) regarding resident 2 revealed: *The resident refused any interventions or teaching regarding her diet restrictions. *She would voice that she understood, but then would go out and buy all sorts of soda and other food and candy she should not have had. -"She drinks 12 pack after 12 pack of pop." *Sometimes she cannot complete her dialysis because she had so much fluid in her. *The dietary department gives her four ounces of juice and milk at breakfast, and four ounces of fluid at the noon and supper meals. -They no longer have dietary cards with instructions on them. -The CSM tells her staff how much fluid she was supposed to get. -She agreed relying only on telling staff what to give her may have been not the best approach. *She drinks so much in her room, and sometimes the certified nursing assistants would give her glasses of water to drink because she would ask</p>	F 281		

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F 281	<p>Continued From page 21</p> <p>for it.</p> <p>-She told them not to do that.</p> <p>-She thought they needed more education on that.</p> <p>*She doubted that the intake records were accurate when it said she only had 500 ccs because she drank all the time.</p> <p>Interview on 7/15/15 a 2:50 p.m. with the director of nurses regarding resident 2 revealed:</p> <p>*She confirmed the above interview with the CDM regarding the noncompliance of the resident.</p> <p>*They probably had not kept track of everything she drank.</p> <p>*She agreed they would not have been following physician's orders for fluid restrictions if they had not been monitoring her fluids.</p> <p>*Their fluid intake policy was not current.</p> <p>Review of the provider's undated Fluid restriction policy revealed:</p> <p>*"Nursing staff and dietary services will provide for restriction of fluids upon order of physician. A fluid intake and output record will be maintained for resident with a fluid restriction order.</p> <p>*Dietary staff will note fluid restriction on diet tray card system.</p> <p>*Nursing staff will provide additional fluid up to limit for each shift. Large quantities of fluids should not be left at the bedside.</p> <p>*Each shift nursing staff will monitor, report/document fluid intake and output.</p> <p>*At the end of each 24 hour nursing staff will tally and record documentation total fluid intake."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 306, revealed "Nurses follow health care provider's orders unless they believe</p>	F 281		

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F 281	Continued From page 22	F 281		
F 329 SS=E	<p>the orders are in error or harm patients."</p> <p><b>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure one of four sampled residents (2) who received an antipsychotic medication (treatment of serious mental illness) had an appropriate indication for</p>	F 329	<p><b>F329</b></p> <p>Will education nurses on appropriate diagnosis with antipsychotic orders on August 7, 2015. The physician ordered a dose reduction of 15 mg of Abilify for two weeks for resident #2. She will be monitored daily with the plan to discontinue Abilify after two weeks. If behaviors re-occur, a new medication will be ordered. The DON will audit all antipsychotics for appropriate diagnosis. The DON will monitor facility antipsychotics use new orders for ninety days and report findings of the audit to the QA Council quarterly for one year.</p> <p><i>je 8/21/15</i></p>	9/1/15

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F 329	<p>Continued From page 23 its use. Findings include:</p> <p>1. Review of resident 2's physician's orders revealed: *From 3/25/14 through 3/17/15 she had received Abilify 15 milligram (mg) one tablet at bedtime. *On 3/17/15 the Abilify was increased to 30 mg one tablet at bedtime. *On 3/25/14 she was started on Celexa (antidepressant) 20 mg one tablet every day.</p> <p>Review of resident 2's progress notes revealed from 2/1/15 through 3/17/15 there was no documentation of any behaviors, hallucinations (seeing things that were not there), or extreme anxiety that would warrant an increase in the antipsychotic medication.</p> <p>Interview on 7/14/15 at 5:00 p.m. with registered nurse A regarding resident 2 revealed she received the antipsychotic medication Abilify for "neurodermatitis." She reported the resident would become anxious and scratched sores in her scalp.</p> <p>Review of resident 2's 3/17/15 physician's progress notes revealed "Has some sores on her left arm and on right shoulder that are scabbed that she wants some salve for. She continues to pick on anything that is open. Will order some bactroban (salve) and bandaids. Will also increase her Abilify."</p> <p>Review of resident 2's 11/8/14 consultant pharmacist medication review revealed: *Recommendations: "Resident is on Abilify, Benadryl, and Celexa with a history of depression/anxiety/neurodermatitis. If a reduction is not appropriate please document rationale to</p>	F 329		

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F 329	Continued From page 24 continue?" *The physician replied "Continues to have open sores in scalp - she scratches when she is anxious." *The pharmacist made no additional recommendations after 11/8/14.  Review of the provider's undated Unnecessary Drugs policy revealed "An unnecessary drug is any drug when used: in excessive dose, excessive duration beyond manufactures recommendation, without adequate monitoring, without indication and appropriate diagnosis for use, in the presence of adverse consequences [side effects] which indicate the dose would be reduced or discontinued or any combination of the above reasons."	F 329			
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 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  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 in the dietary department for the following:	F 371	F371 The Dietary Staff will be in-serviced on August 10, 2015 about maintaining a clean and sanitary dining and kitchen area, as well as serving meals correctly. A new cleaning schedule was implemented on July 27, 2015. The policy was updated to reflect the changes. The towel was removed from the hood. Maintenance Tech will reseal the roof flashing around the vent on roof and will caulk all joints on the fan housing. One microwave was replaced with a new microwave on July 14, 2015 and the other 2 were cleaned immediately. We identified 7 microwaves in the facility, they were added to the daily and weekly cleaning schedule. The policy will read: "clean microwave after each meal service". Dietary Manager counseled cook E and B about not serving over prepared food. They will serve above the sneeze guard in North Dining Area and at the end of the steam table on East Dining Area. Dietary Manager will audit 3 meal randomly	(8/7/15)	9/1/15

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F 371	<p>Continued From page 25</p> <p>*One of one exhaust fan in the kitchen was free from water leaks.</p> <p>*Three of four microwaves (kitchen, north dining room, and east dining room) had not been clean.</p> <p>*One of two observed meal services in the north dining room had been served under sanitary conditions by one of two cooks (E). Findings include:</p> <p>1. Observation and interview on 7/14/15 at 8:45 a.m. with the dietary manager (DM) in the kitchen revealed: *An exhaust fan attached to the ceiling. That exhaust fan had been located above the cook stove and a food preparation (prep) table. *Underneath the exhaust fan had been a small metal shelf with a white towel that had a discoloration appearance of reddish/orange. *The towel had been on that shelf for sometime. *When it rained outside the exhaust fan would leak water, and had been an issue for a long time. *The towel had been placed on that shelf to ensure no water had leaked down onto the cook stove or food prep area. *The DM agreed: -This had not been a sanitary approach to ensure rain had not dripped down onto the food cooking on the stove or prepped on the table. -That should have been fixed when the issue had started.</p> <p>2. Random observations on 7/14/15 of three microwaves revealed: *They had brown, yellow, and tan colored debris on the doors, all three sides, and on the top. *The east dining room microwave revealed a small rust colored hole approximately half a centimeter (measurement) in size on the top.</p>	F 371	<p>services per week and do a weekly walk through to identify any unsanitary issues and will address them promptly.</p> <p>Audits and walk through will be reviewed by Administrator and Dietary Manager, the findings from the audits will be brought to the Quality Assurance Committee quarterly for six months by Dietary Manager.</p> <p><i>of 8/21/15</i></p>	

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F 371	<p>Continued From page 26</p> <p>Surrounding that hole and rust colored area had been black and gray marks indicative an arcing exit.</p> <p>Interview on 7/14/15 at at 8:50 a.m. with the DM regarding the three microwaves revealed: *She had not been aware the microwaves were dirty. *The dietary staff had been responsible for the cleaning of the microwaves. *She would randomly leave a note for the staff to clean the microwaves. *She agreed they were not clean and had not been used under sanitary conditions. *The east dining room microwave had been unsafe to use and needed to be replaced immediately.</p> <p>3. Observation on 7/14/15 of cook E during the noon meal revealed: *She had been serving the noon meal in the north dining room. *The food wells for the hot food had been placed in the steam table. *There had been two food wells that had not been able to fit into the steam table. Those two food wells had been opened and placed on top of the other wells. *Inside of those two wells had been mashed potatoes and carrots. *Above the steam table there was a large sneeze cover with a shelf on top of it. *During the serving process of the noon meal cook E had handed all of the plates of food to various staff members. Those plates of food were than served to the residents. *Cook E handed all of those plates of food to the staff members underneath of the sneeze guard and over the two opened wells of mashed</p>	F 371			

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F 371	Continued From page 27 potatoes and carrots.  Interview on 7/15/15 at 8:20 a.m. with the DM regarding the above observation confirmed cook E should have handed the plates to the staff above the sneeze guard. She agreed the food for the residents had not been served in a sanitary manner.  Review of the provider's 2012 Cleaning Procedures policy revealed: *Microwave ovens: -"Wipe out spills and spatters with detergent solution as they occur daily. -"Frequency of cleaning - weekly, and wipe out after each use, daily."  Review of the provider's undated Scope of Meal Service policy revealed no procedure in place for the staff to follow when serving and using a steam table with an attached sneeze guard.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431	F-431 Educate to nursing staff done on August 7, 2015. Policy was revised so that both opened and used by dates will be recorded on label. Resident's 2,3,15,16, and 17's insulin's were discarded and new were ordered and received and dated appropriately. Refrigerators on East wing were removed and replaced with new on 7/23/15. New temp logs created for refrigerators with comment section. DON will monitor compliance of proper dating of all insulin's in facility monthly for three months.*Housekeeping supervisor will audit fridge temps on East wing weekly. Results will be presented at QC meeting quarterly for two quarters.  * and will continue doing random monthly audits for one year.	8/3/15

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F 431	<p>Continued From page 28 applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on medication cart review, insulin refrigerator log review, interview, manufacturer's guidelines, and policy review, the provider failed to ensure: *Used by dates were written on all insulin bottles for five randomly selected residents (2, 3, 15, 16 and 17) receiving insulin. *An insulin pen found in one of two medication carts (east) had the appropriate labeling to identify it prior to use on one of one resident (3). *Insulins kept in the east medication refrigerator were held above freezing temperatures. Findings include:</p> <p>1. Medication cart review and interview on 7/14/15 at 2:45 p.m. at the east nurses station</p>	F 431			

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F 431	<p>Continued From page 29</p> <p>with registered nurse (RN) A revealed:</p> <ul style="list-style-type: none"> <li>*Insulin bottles that were currently in-use had no used-by dates written on them.</li> <li>*Insulins not marked included: <ul style="list-style-type: none"> <li>-Humalog, Novolog, and Lantus. Those medications expire and must be discarded twenty-eight days after first use.</li> <li>-Levemir insulin expires forty-two days after first use.</li> </ul> </li> <li>*RN A stated staff would not write that date on them as they used the manufacturer's expired date.</li> <li>*She agreed the insulin medications expired within a specific time-frame once opened and used, and the manufactures' expiration date was for shelf-life.</li> </ul> <p>Interview on 7/15/15 at 4:30 p.m. with the director of nursing (DON) regarding the Insulins revealed she agreed:</p> <ul style="list-style-type: none"> <li>*Staff had never written the used-by date on the insulin bottle after first opened and used.</li> <li>*She agreed manufacturer's labeling instructions should have been followed.</li> </ul> <p>Review of the current manufacturer's guidelines package insert for the above medications received on 7/14/15 from RN A revealed Novolog, Humalog, and Lantus were to be discarded after twenty-eight days of first used. Levemir was to be discarded after forty-two days after first used.</p> <p>Review of the provider's 3/17/15 Medication Administration policy revealed all sterile multi-dose vials (including insulin) was to be dated upon opening.</p> <p>2. Medication cart review and interview on 7/14/15 at 2:45 p.m. at the east nurses station</p>	F 431			

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F 431	<p>Continued From page 30</p> <p>with registered nurse (RN) A revealed: *A lantus insulin pen was being used for resident 3 that had no resident information on it. *RNA was unsure why pharmacy had not labeled that insulin pen. *She stated she had been using it on resident 3. *Only two other residents (16 and 17) used that form of insulin, and their's had been labeled so she knew it was resident 3's.</p> <p>Interview on 7/15/15 at 4:30 with the director of nursing (DON) regarding the insulins revealed she was unsure why pharmacy had not affixed a resident label to the lantus pen.</p> <p>Review of the provider's 3/17/15 Medication Administration policy revealed: *Staff were to have checked labels for accuracy. *The label was to have been read and checked against the medication administration record prior to administration for discrepancies. *Staff were to use the six rights of medication administration to include the right patient and the right medication.</p> <p>3. Review of the insulin refrigerator review located by the east nurses station with registered nurse (RN) A revealed: *Various types of insulin stored in the refrigerator included Humalog, Novolog, Levemir, and Lantus. *Temperature logs from January 1, 2015 through July 14, 2015 had fifty-eight days where temperatures were at or below freezing (32 degrees or less). *RNA had not known temperatures were at or below freezing, or that manufacturers' instructions specifically stated to not freeze or use the insulins if frozen.</p>	F 431			

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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
F 431	Continued From page 31	F 431		
F 441 SS=E	<p>Review of the current manufacturer's guidelines package insert for the above medications stated they were not to have been frozen or used if they were known to have been frozen.</p> <p>Review of the provider's undated Storage of Medications policy revealed "refrigerator temperatures should be between 34 and 40 degrees."</p> <p><b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p>	F 441	<p>F-441 All staff in-service done on August 6, 2015.</p> <p>Resident #14 back of electric chair will be repaired with a vinyl repair kit that will be applied to the exposed wood area. The Restorative Program will do a monthly wheelchair audit to identify un-cleanable surface area. C.N.A's will make referrals when cleaning chairs to restorative program.</p> <p>We will purchase closed containers that will hold personal care items. Will place a name label on them and kept separated from roommates.</p> <p>We updated cleaning schedule for weekly cleaning of stand lifts. Sanitizing wipes are made available to clean lift between resident uses. Maintenance Tech painted all lifts that are showing wear with quality enamel paint. These audits* will be reviewed monthly at the Infection Control Committee and quarterly at the Quality Council.</p>	9/1/15  (8/12/15)  <i>8/21/15</i>

\* Wheelchair repair and stand aid lift cleaning.

*8/21/15*

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F 441	<p>Continued From page 32</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure: *One of three resident's (13) randomly observed electric wheelchairs (w/c) had clean surfaces. *Resident use items for personal care had been marked and identified for four of six randomly observed shared resident rooms ( 106, 107, 109, and 204). *Two of two stand lifts (equipment used to transfer residents from one place to another) located in the north hallway were maintained and clean from dirt and debri. Findings include:</p> <p>1. Random observations from 7/13/15 through 7/15/15 of resident 14's electric w/c revealed: *The entire seat had a vinyl covering, and both corners on the top of the back rest had missing pieces of vinyl. *Those missing pieces of vinyl had left exposed areas of wood and created uncleanable surfaces.</p> <p>Interview on 7/15/15 at 11:15 a.m. with the maintenance supervisor revealed:</p>	F 441			

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F 441	<p>Continued From page 33</p> <p>*He had not been aware the electric w/c had missing pieces of vinyl.</p> <p>*He agreed those exposed areas of wood had been uncleanable.</p> <p>*The restorative aide had been responsible for informing him of any concerns with the residents' w/cs.</p> <p>*He did not have a routine preventative maintenance program in place to monitor and check the w/cs to ensure they remained in good repair.</p> <p>2. Random observations from 7/13/15 through 7/15/15 of residents rooms 106, 107, 109, and 204 revealed:</p> <p>*They had shared a room with another resident.</p> <p>*There had only been one sink in those resident rooms.</p> <p>*On those sinks there had been multiple personal care items. Those items had been unmarked with no resident names that made them unidentifiable for the staff when doing personal care.</p> <p>*Those unmarked items were:</p> <ul style="list-style-type: none"> <li>-Comingled (placed) together.</li> <li>-Toothbrushes.</li> <li>-Drinking glasses.</li> <li>-Toothpaste.</li> <li>-Body wash.</li> <li>-Two bars of soap in room 204. Those used bars of soap were not inside marked containers and had been placed directly on the sink.</li> </ul> <p>3. Interview on 7/15/15 at 3:05 p.m. with the director of nursing (DON) revealed:</p> <p>*She had been aware resident 14's w/c had areas of exposed wood and those areas created uncleanable surfaces.</p> <p>*All resident use items for personal care should have been marked with their names to ensure</p>	F 441			

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F 441	Continued From page 34 they were identifiable. *She agreed both of the above areas of concern had created the potential for cross-contamination to the residents.  Review of the provider's undated Personal Care Items policy revealed: *Standard "There is an organized system to monitor and prevent the development and transmission of nosocomial infections [infections acquired while a resident at that facility] through proper maintenance of equipment." *No process in place to identify what that organized system was.  Surveyor: 33488 3. Observations from 7/13/15 through 7/15/15 and interview on 7/15/15 at 2:00 p.m. with the administrator of the two stand lifts (lift used to assist residents from a sitting to a standing position) located on north revealed: *They were both heavily soiled with dirt and debris. *He agreed they should be cleaned if visibly dirty and after each resident use.  There was no policy on stand lift cleaning upon being requested.	F 441			
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION  The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.  This REQUIREMENT is not met as evidenced by:	F 456	F-456 Maintenance Supervisor will remove light fixture with cracked glass cover and seal the opening. The Maintenance Supervisor does have a preventative maintenance plan that addresses doing daily, monthly, quarterly, semi-annual and annual inspections of equipment and requirements of SDDOH regulations. The light covers will be added to his preventative plan and will be checked monthly. The Maintenance Supervisor and the Administrator will review the preventative plan monthly. The safety issues identified on the plan will be discussed quarterly at both the Safety Committee and the Quality Council.	9/1/15	

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F 456	<p>Continued From page 35</p> <p>Surveyor: 33488</p> <p>Based on observations and interview, the provider failed to have a preventative maintenance program. Findings include:</p> <p>Surveyor: 32355</p> <p>1. Observation on 7/14/15 at 9:00 a.m. of two light fixtures above the cook stove and a food preparation area revealed:</p> <ul style="list-style-type: none"> <li>*Both of the lights had glass covers over the light bulbs.</li> <li>*One of the light bulb covers had a large crack in it.</li> </ul> <p>Interview on 7/14/15 at 1:20 p.m. with the dietary manager revealed:</p> <ul style="list-style-type: none"> <li>*She had not been aware one of the light bulb covers had a crack in it.</li> <li>*She agreed that had created the potential for an unsafe environment when cooking and preparing the residents' food.</li> </ul> <p>Interview on 7/15/15 at 11:25 a.m. with the maintenance supervisor revealed:</p> <ul style="list-style-type: none"> <li>*He had been working for the facility for three months.</li> <li>*During his orientation the previous maintenance supervisor had brought the cracked light bulb cover to his attention. He had been informed to "Be careful when changing that light bulb, because the cover is cracked and could break."</li> <li>*He had not been aware: <ul style="list-style-type: none"> <li>-The cracked light bulb cover should have been replaced.</li> <li>-That had created an unsafe environment for cooking and preparing the residents' food.</li> </ul> </li> </ul> <p>Surveyor: 33488</p> <p>2. Review of observations and interview on</p>	F 456			

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F 456	<p>Continued From page 36</p> <p>7/15/15 from 10:00 a.m. to 10:30 a.m. and again at 2:00 p.m. with the maintenance supervisor and the administrator revealed:</p> <p>*The maintenance supervisor had been employed at the facility for approximately three months.</p> <p>*He was unaware he should have a preventative maintenance plan in place to ensure resident safety and well-being while they resided at the facility.</p> <p>*The maintenance supervisor confirmed his practice was to fix items if they were brought to his attention that they needed repair.</p> <p>*The administrator agreed the facility needed a preventative maintenance plan.</p> <p>Review of the provider's undated Environmental Services Policy and Procedures policy revealed:</p> <p>*Preventative maintenance schedules and inspections were to be conducted daily, monthly, quarterly, semi-annually, and annually.</p> <p>*Items inspected for safety included resident use items such as call light systems, grab bars in toilets, and mechanical lifts.</p>	F 456			

# ORIGINAL

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NAME OF PROVIDER OR SUPPLIER  <b>TEKAKWITHA NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6 E CHESTNUT SISSETON, SD 57262</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/21/15. Tekakwitha Nursing Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 7/23/15 upon correction of the deficiencies identified below.</p> <p>Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K038, K047, and K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
K 033 SS=C	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and record review, the provider failed to maintain a one hour fire rated protected path of egress from a stair enclosure to</p>	K 033		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>James P. Coulter</i>	TITLE <i>Administrator</i>	(X6) DATE <b>8/5/15</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 033	Continued From page 1 the exterior of the building for three randomly observed stairways (north, basement, and second floor). Findings include:  1. Observation at 1:15 p.m. on 7/21/15 revealed the north stairway from the basement discharged into a main level vestibule. The vestibule was not separated by a one hour fire resistive construction. Further observation at 1:30 p.m. revealed the basement and second floor stairways to the pre-school areas discharged into the main level corridor system. Review of previous survey data indicated that condition was part of the original construction.  The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiencies identified in K000.	K 033		
K 040 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5  This STANDARD is not met as evidenced by: Based on observation and record review, the provider failed to maintain clear door widths of at least 32 inches for one randomly observed set of exit access doors (double-door number 7). Findings include:  1. Observation at 1:30 p.m. on 7/21/15 revealed the leaves for double-door number 7 between the stairwell and the corridor were only 30 inches	K 040		F

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K 040	Continued From page 2 wide. They did not provide a clear opening width of 32 inches. Review of the previous survey report confirmed the doors were part of the original construction.	K 040			
K 047 SS=D	The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiencies identified in K000. NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 047	K47 The EXIT light bulb was replaced on July 29, 2015. We identified 29 EXIT lights in facility during walk through, there was one light needing new bulbs, replaced them on July 29, 2015. The Maintenance Department will add EXIT lights to their monthly checklist. The checklist will be reviewed with the Administrator and reported to the Safety Committee. The Administrator will report the non-compliance findings to the Quality Council each quarter or until advised to discontinue.	8/15/15	
K 130 SS=C	This STANDARD is not met as evidenced by: Based on observation, document review, and interview, the provider failed to maintain exit signs with continuous illumination. One randomly observed exit sign for the chapel was not illuminated. Findings include:  1. Observation at 1:45 p.m. on 7/21/15 revealed the exit sign for the west exit from the chapel was not illuminated. Interview with the administrator at the time of the observation confirmed that finding.  The deficiency affected one of numerous exit signs for the building. NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		F	

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K 130	Continued From page 3  This STANDARD is not met as evidenced by: Based on observation, measurement, and interview, the provider failed to maintain exit and exit access, so a dead-end corridor did not exceed thirty feet. Findings include:  1. Observation and measurement at 1:00 p.m. on 7/21/15 of the south corridor from the south, east-west corridor to resident rooms 207, 208, 209, and 210 was not provided with an exit. The dead-end corridor measured seventy-two feet in length. Interview with the director of maintenance at the time of the observation revealed during a remodel of that area the exterior door had been removed.  The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiencies identified in K000.	K 130			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>435038</b>	MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - MAIN BUILDING 01</b>  B. WING _____	DATE SURVEY COMPLETE:  <b>7/21/2015</b>
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<b>K 038</b>	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1.19.2.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to ensure exits were readily accessible at all times. Two magnetically locked doors at the north exit were not equipped with signage that indicated how to open a magnetically locked delayed egress door. Findings include:</p> <p>1. Observation at 1:45 p.m. on 7/21/15 revealed the north exit doors (employee entrance) were equipped with magnetically locking hardware. Testing of the magnetically locked doors at the time of the observation revealed they were delayed egress type doors. Interview with the administrator at the time of the observation revealed he was unaware the signs were required.</p> <p>The deficiency affected one of several requirements for delayed egress magnetically locked doors and had the potential to affect the residents in two of four smoke compartments.</p>
<b>K 069</b>	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on document review and interview, the provider failed to conduct the required annual inspection of the kitchen range exhaust ductwork. Findings include:</p> <p>1. Document review on 7/21/15 at 2:45 p.m. of the kitchen hood system revealed there was no documentation indicating the exhaust ductwork had been thoroughly inspected for cleanliness/grease build-up. There was no documentation indicating the exhaust ductwork had been cleaned from the ventilator on the roof down to the range hood. Interview with the administrator at the time of the document review revealed the inspection and subsequent cleaning had been overlooked since the previous maintenance supervisor ceased employment for the provider. He stated an inspection/cleaning would be scheduled as soon as possible.</p> <p>The deficiency affected one of several requirements for protecting cooking facilities.</p>

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>435038</b>	MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - MAIN BUILDING 01</b> B. WING _____	DATE SURVEY COMPLETE: <b>7/21/2015</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<b>K 069</b>	Continued From Page 1
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**ORIGINAL**

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10685</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/21/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TEKAKWITHA NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6 E CHESTNUT SISSETON, SD 57262</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>Initial Comments</p> <p>Surveyor: 33488 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/13/15 through 7/15/15 and on 7/21/15. Tekakwitha Nursing Center was found in compliance.</p>	S 000		

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

*James J. Cornelia*

TITLE

*Administrator*

(X6) DATE

*8/5/15*