

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

ORIGINAL

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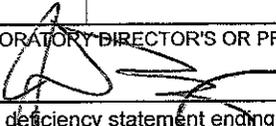
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/25/2014
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NAME OF PROVIDER OR SUPPLIER  CLARKSON HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MT VIEW RD RAPID CITY, SD 57702
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F 000	INITIAL COMMENTS  Surveyor: 22452 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/19/14 through 8/21/14 and on 8/25/14. Areas surveyed included resident transfer safety with the use of mechanical lifts and resident neglect. Clarkson Health Care was found not in compliance with the following requirements: F225, F226, F279, F309, F323, and F490.	F 000		
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225	F225 Clarkson Health Care Facility operates in a capacity ensuring quality of care and services to our residents.  Facility adheres to the State and Federal guidelines by staying within regulatory compliance under the direction in which we are licensed.  Items listed in this report have a coinciding correction listed in the right hand column.  Requested updates to Abuse Policy were completed and found to be satisfactory by survey team as noted on 8/21/2014.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Administrator

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OCT 10 2014  
SD DOH L&C

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 225	<p>Continued From page 1</p> <p>prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to appropriately investigate, assess, document, and report extensive bruising of unknown origin the cause unknown) for one of one sampled resident (1) who was dependent on staff to meet all her mobility needs and required a mechanical lift (equipment to help lift and move residents) for transfers.</p> <p>NOTICE:</p> <p>Notice of immediate jeopardy was given verbally to the administrator and the director of nursing on 8/20/14 at 5:20 p.m. They were asked for a plan of correction to be given to the surveyors on 8/21/14 at 8:00 a.m. They were asked that the plan of correction include: *The investigation and reporting of bruises and injuries of unknown origin for all residents. *The assessment and documentation of bruises and injuries of unknown origin for all residents.</p>	F 225	<p>As part of ongoing process, any and all abuse reporting as well as investigations will be reviewed at QA Committee meeting and Medical Director meetings and follow up on any additional direction given by both.</p> <p>As provided, all staff members at the facility have been educated, inserviced, given a copy of and reviewed all policy and forms utilized in defining what abuse is, who to report it to and what the expected follow up is.</p> <p>As an ongoing process, any reports of known and unknown bruising, incidents, etc., are reported to Nurse Administration and reviewed within the interdisciplinary team to ensure proper follow up.</p>		

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F 225	<p>Continued From page 2</p> <p><b>PLAN:</b> A plan of correction for the reporting and investigation of bruises and injuries of unknown origin was accepted on 8/21/14 at 8:55 a.m. The plan of correction also included a revised abuse policy that contained the seven required components of abuse and neglect. The immediate jeopardy was abated. The plan was as follows: *Changes were made to the Abuse policy to reflect compliance with regulatory guidelines in regards to: -Screening of potential employees. -Training of employees. -Prevention. -Identification. -Investigation. -Protection. -Reporting/Response. *Investigations going forward would be completed relevant to state and federal regulations. Use paper and electronic nursing policy and procedure manuals. *Initial 24 hour reporting would be completed by the director of operations /director of nursing (DON)/Nurse on duty to comply with state regulations. As warranted a five day reporting will be completed by the director of operations or the DON. *Implementation to achieve compliance: -Interim stand-up meeting would be held to discuss new policy and procedure for abuse at the beginning of each shift change until the formal staff mandatory meeting on 8/27/14. Documentation and verbiage provided would be the new policy and procedure for abuse, the initial reporting form, and the Nursing Facility Injury of Unknown Source Reporting Flow sheet. *All staff meeting would be held on 8/27/14 to</p>	F 225	<p>Interim Stand Up meetings were completed by DON/Administrator with all nursing personnel at each shift change until formal meeting was conducted on 8/27/2014, at which time all departments were provided with complete education regarding changes to Abuse Policy as outlined by regulatory guidance provided regarding "Seven Components of Abuse Prohibition Worksheet."</p> <p>The updated policy outlines the process by which injuries will be prevented, identified, investigated, protected and reported.</p> <p>Facility will notify appropriate agencies of ongoing investigation within 24 hours in accordance with state law and will report to the Department of Health with final investigative report within 5 days.</p> <p>Incident reports will be completed as indicated.</p>		

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F 225	<p>Continued From page 3</p> <p>include all departments in the facility.</p> <p>*Each staff member who was not able to attend the meeting on 8/27/14 would be provided with individual education and resources by the DON or DOO by 8/29/14.</p> <p>*All staff would sign acknowledgement form of understanding the policy and procedure.</p> <p>*Education to the nursing department would include the expectation that all bruising would be reported to the charge nurse, who would then report to DON/nursing administration/DOO.</p> <p>During the extended survey on 8/25/14 at 9:30 a.m. the surveyors confirmed removal of the immediate jeopardy and the above plan of correction. Findings included the initial 24 hour reporting had been completed on 8/21/14 for:</p> <p>*Resident 4; "Bruise noted to bilateral knees, left forearm, right elbow, and right upper thigh. No specific known cause, and resident not capable of participating in interview. Five day report to follow."</p> <p>*Resident 9; "Bruise noted to right arm, left elbow/wrist, and bilateral shins (front of lower legs). No specific known cause and resident not capable to participate in interview. Five day report to follow."</p> <p>*Resident 12; "Bruise noted to right leg and right forearm. Both measure 2.0 by 1.0 centimeter (cm) in size. No specific cause and resident not capable to participate in interview. Five day report to follow."</p> <p>Additional findings included:</p> <p>1. Review of resident 1's 6/18/14 through 6/20/14 interdisciplinary notes by the following staff revealed:</p>	F 225	<p>Administrator/DON or designee will audit all incident reports weekly and report investigation findings monthly to the QA Committee.</p> <p>Completed 5-day investigation process on residents 4, 9, 12 on 8/26/2014 with appropriate interventions in place to prevent future occurrences.</p> <p>No abuse or neglect substantiated.</p> <p>Administrator, DON, ADON and MDS Coordinator reviewed all residents in facility to ensure compliance with most current abuse policy.</p>		

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F 225	Continued From page 4 *6/18/14 at 11:30 a.m. by registered nurse (RN) Q: "Received in report resident became weak during transfer with stand-up lift [lift that requires resident to be able to bear some weight on legs]. This morning resident noted to have approximate 18.0 by 17.0 cm bruise to right underarm that extends to the breast. Resident reported area to be tender to touch (TTT). Daughter called with update. Staff made aware and treatment administration record (TAR) updated to monitor every day until resolved. TAR updated related to size of bruise and resident having order for coumadin [blood thinning medication]. Doctor updated via fax. Director of nursing (DON) updated head of bed (HOB) to indicate Hoyer [lift that uses sling and resident does not have to bear any weight on legs] transfer." *6/18/14 at 1:20 p.m. by RN Q: "Doctor acknowledged bruise to right underarm. No new orders." *6/18/14 at 2:24 p.m. by RN Q: "Received phone call from doctor's office to repeat laboratory tests of complete blood count (CBC), complete metabolic panel (CMP), international normalized ratio (INR), and straight catheter urinalysis. Resident has appointment for 6/20/14 at 10:00 a.m. for chest x-ray. Daughter aware as she had already called doctor's office." *6/18/14 at 10:05 p.m. by RN E: "Resident weak this evening. Remained in bed all shift. Repositioned. Resident assisted with supper. Resident only would eat one-half of jello and refused rest of supper. Resident taking fluids well and offered frequently." (There was no documentation of the bruised area or pain from that area). *6/19/14 at 7:38 a.m. by licensed practical nurse (LPN) HH: "Lab here and drew CBC, CMP, and INR from left arm and picked up urinalysis."	F 225	Resident 1's medications included Aspirin and Coumadin and additional review of patient's history on skin documentation of patients previous predisposition to bruising and other related medical information was completed by the Medical Director and presented during the survey.  Resident 1 has since passed away, so there is no further intervention put in place for this resident.	9-20-14

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F 225	<p>Continued From page 5</p> <p>*6/19/14 at 3:14 p.m. by RN D: "Resident this morning with overall worsening of condition, significant bruising to right side, pulses weak and thready [irregular and faint] to all four extremities [arms and legs], color pale and skin cool to touch. Resident arousable [can awaken] but lethargic [sleepy]. Respirations [breathing] even but labored with oxygen at 3 liters per nasal cannula. Family called and updated on resident condition. Family to meet with this writer at 10:30 a.m. to discuss current condition and plan of care. Labs [laboratory test results] received at 10:30 a.m. Family present and physician notified via phone of critical abnormalities. Physician spoke with daughter and initially provided order for intravenous [IV] hydration and antibiotics. Daughter asked about hospice once off the phone with the physician. Physician called back stating he would be in to meet with the family at 12:45 p.m. IV orders discontinued at this time and hospice ordered. Hospice referral made by social services coordinator and hospice admission expected tomorrow."</p> <p>*6/19/14 at 11:04 p.m. by RN II: "Resident is being turned every two hours with oral cares provided. Hospice nurse K here at 7:30 p.m. to talk with family and discussed with nursing here that the admit to hospice will most likely occur tomorrow. Resident has increased heart rate at 120 (normal 60 to 80 beats a minute), and her toes are cold at this time. She is lethargic but arousable. Respiratory rate 20. She is on 3 liters of oxygen. Family was consulted about beginning use of morphine (narcotic pain medication) for comfort. Education was given regarding the disease process, progression, and possible pain that would be associated with this process. Resident is wincing during position changing however is not verbalizing pain. She does not</p>	F 225			

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F 225	<p>Continued From page 6</p> <p>wince when lying still. Family decided it would be okay to start the morphine at this time." *6/20/14 at 6:35 a.m. by RN JJ: "Resident repositioned three times this shift when requested and allowed by family. Resident minimally responsive. Can swallow small sips of water. Comfort cares given." *6/20/14 at 2:26 p.m. by RN Q: "Hospice nurse H in to see resident at 9:50 a.m. Daughter reported at 12:15 p.m. that mother was not breathing. No breaths or heart beat and verified by second nurse. Daughter very teary eyed and emotional support given."</p> <p>Review of resident 1's 6/19/14 at 6:57 a.m. skin assessment form documentation by RN B revealed: *"Blue bruises noted to bilateral shins and purple bruises to bilateral forearms. Circulation, motion, and sensation (CMS) altered to right arm pain." *"Noted to have extensive, deep, purple bruising to right axilla (armpit), right side extending to right hip and right breast with bluish bruising to sternum (breastbone) and 10.0 by 8.0 firm mass (deformity) to right upper chest." *"Resident complains of pain upon movement and palpitation (touching)." *"Conferenced with day nurse regarding appearance of bruising and presence of deformity. Will administer pain medication and follow-up promptly. (Review of 6/19/14 medication record revealed acetaminophen was administered for pain at 7:20 a.m. with no documentation if medication was effective for relieving pain).</p> <p>Interview on 8/19/14 at 11:20 a.m. with the DON regarding resident 1 revealed: *She did not report or investigate the multiple</p>	F 225			

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F 225	Continued From page 7 bruises of unknown origin "because they knew they had happened during an unsuccessful transfer with the stand-up lift." *There was no documentation when the unsafe transfer had happened. Since it had been passed on in report on 6/18/14 in the morning, it was thought to have happened at bedtime on 6/17/14. *An incident report had not been made out by staff working at the time when the bruises had been discovered. They had not utilized incident reports for quite a long time. *The expectation was that the nursing staff would document all pertinent information in the medical record. *She agreed the bruises and the unsafe transfer should have been documented in the medical record when it had happened. *Any investigations would have been also documented in the medical record. The nurse who discovered the bruises should have documented in the medical record. *It had been discussed that she did not tolerate the stand-up lift on 6/17/14. She had informed the nursing staff on 6/18/14 she should be a Hoyer lift for further transfers. *She agreed there was documentation on 6/9/14 in the interdisciplinary notes the resident had become weak. It stated staff needed to use the Hoyer lift to transfer her. The use of the Hoyer lift was not made a permanent change on 6/9/14. *Their policy was staff could always go up with transfers (if a resident was a stand-up lift the staff could use a Hoyer lift if needed), but could not go down with transfers (if a resident was a Hoyer lift than a stand-up lift could not be used). *RN Q had informed the physician of the resident's bruising on 6/18/14, and it was felt the resident could not tolerate an x-ray. She confirmed RN Q should have documented that.	F 225			

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F 225	<p>Continued From page 8</p> <p>*She did not feel the resident was in pain when lying still on 6/18/14, so the nurses had not given her any pain medication. The only time the resident was uncomfortable was when the bruised area was palpated.</p> <p>*When the physician had seen the resident on 6/19/14 he had discussed with the family she was actively dying. The family had decided on hospice care.</p> <p>* She stated, "The reality of the situation (the critical labs) over shadowed the critical condition."</p> <p>*RN D's documentation on 6/19/14 showed she had done an assessment on the resident and had discussed her deteriorating condition. She had informed the physician at 10:30 a.m. when her laboratory results had come back.</p> <p>*She felt it was following RN D's skin assessment, change in bruising for resident 1, RN D had made the determination not to call the physician.</p> <p>*It was okay for RN D to take over calling the resident's physician and family as she "didn't want three nurses calling."</p> <p>*She confirmed there was no documentation from 6/14/14 through 6/18/14 to reflect her progressive declining condition.</p> <p>**I document only if there is anything in addition to the nurses' documentation."</p> <p>*The resident did not fall or was she dropped. She knew that by the information that had been passed on to her by the nursing staff.</p> <p>Interview on 8/19/14 at 1:35 p.m. with RN B regarding resident 1 revealed:</p> <p>*On 6/19/14 she was doing her weekly skin assessments on residents.</p> <p>*She had done the resident's skin assessment about 6:00 a.m. and had RN Q hadf come in the room with her. RN Q had seen the bruising on</p>	F 225			

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F 225	Continued From page 9 6/18/14, and she had not. *She recalled RN Q making the comment the bruising "was more extensive." *She had been informed the bruising had occurred when the resident had become weak in the stand-up lift, and the Hoyer lift was to be used for transfers. *She was not sure why RN Q had not documented on the bruising on the resident's shins, hip, and right axilla on 6/18/14. She would have to check RN Q's notes. *The resident often had bruising on her shins and forearms "because she was on coumadin." *She confirmed the resident was having pain when the bruised area on her breast was palpated. She had informed RN Q of the pain. She was not sure what medication had been given for pain or that no follow-up was done if the medication (acetaminophen) had been effective. *She normally did not measure bruised areas when she did her skin assessments unless "they were significant." She was unable to elaborate what "significant" meant, but she agreed the resident's bruising as noted above was "significant." *She and RN Q had talked about notifying the resident's physician after she had completed her skin assessment. *She had been informed (unsure of by whom) that RN D would be taking over the care of the resident and talking to her family and the physician. She was unsure why RN D was to take over the resident's care since she was not her charge nurse that day. But she had been told RN D knew the family well from working with them during care conferences. She thought RN D "just wanted to help." She thought RN D likely did another assessment of the resident when "she took over her care on 6/19/14."	F 225			

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F 225	<p>Continued From page 10</p> <p>*She was not sure what RN D had informed the resident's family or physician but "it would be in her notes."</p> <p>*She was unsure if she and RN Q had talked to RN D about their concerns the physician should have been updated and the resident possibly evaluated in the emergency room.</p> <p>*She was not sure when RN D had informed the physician regarding the significant changes in her bruises.</p> <p>*The resident had been able to visit with her that morning during her skin assessment, but "nothing in depth." She was not entirely sure if the resident at that point could have told her "where she had gotten all the bruises."</p> <p>*The resident had been failing and was more confused.</p> <p>*She was not involved with the resident after her skin assessment on 6/19/14 at 6:57 a.m. She assumed RN D and the DON were handling things; "I was told RN D was handling things."</p> <p>Interview on 8/19/14 at 2:30 p.m. with certified nursing assistant (CNA) II C regarding resident 1 revealed: "She didn't really remember caring for the resident that week." (The nursing schedule reflected she worked the day shift on 6/17/14, 6/18/14, and 6/20/14).</p> <p>*The resident was on the list the "float CNA" took care of, but she was unsure who the float CNA had been those days. She had not been responsible for the resident's care but knew she had assisted the float CNA with repositioning her.</p> <p>*She had taken care of the resident many times before 6/17/14.</p> <p>*"I remember the float CNA calling for help to move and reposition her."</p> <p>*"I don't remember using a lift on her. I think she</p>	F 225			

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F 225	<p>Continued From page 11</p> <p>stayed in bed and we turned her." **She recalled seeing some bruising. The bruising was on one side up to her chest. I thought I heard she had a fall but do not recall anything else." She had gotten report from the CNA who had "worked the shift before her on 6/18/14." *She confirmed the resident "had a fast decline from the week before." **"She was not in any distress that I remember." **"Her decline could have possibly started around the time the bruising occurred."</p> <p>Interview on 8/19/14 at 2:50 p.m. with RN D/Minimum Data Set (MDS) coordinator regarding resident 1 revealed: *She usually worked three to four days a week doing MDS/care plans and one to two days a week as a nurse on the floor. *She usually worked on Elm/Oak wing when she worked as a nurse on the floor. (Resident 1 resided on Aspen wing.) **"Every morning when I come I check with the charge nurse to find out what is going on and if I can help." **"On 6/19/14 RN B and RN Q had told her there was a change with the resident. I went and did an assessment on the resident and offered to call the family and the physician for them. *She had not been involved with the resident on 6/17/14 or 6/18/14. **"I can't go back and tell you what my conversation with RN B and RN Q on the morning on 6/19/14 was about. I can not tell you anything outside of what my notes state." **"I informed the family regarding her overall condition after I had assessed her." *The physician was informed of her abnormal laboratory results on 6/19/14 at 10:30 a.m. She</p>	F 225			

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F 225	<p>Continued From page 12</p> <p>had not thought it necessary to call the physician prior to that on 6/19/14 after she had spoken to the family.</p> <p>***"It is standard practice to ask the family what they want done for the resident."</p> <p>*She did not comment when asked if she felt the resident's bruising was alarming.</p> <p>*After she had completed her assessment she had felt comfortable calling the resident's family and physician. She had not documented what she had informed the family or physician "just her change in condition." "I would have updated them on her condition and the bruising."</p> <p>***"I think her condition progressively declined from 6/19/14 to 6/20/14."</p> <p>*The physician had called with orders on 6/19/14, and then came in to see the resident.</p> <p>***"I do not recall either RN B or RN Q telling me on 6/19/14 they thought she needed to see a physician after their assessment at 6:57 a.m., or otherwise I would have called the physician."</p> <p>***"We do monitor bruises if they are significant." (She was unable to elaborate what significant meant.)</p> <p>***"Her bruising was over shadowed by a declining resident and dying."</p> <p>***"It's up to the family if they want them sent out (referring to the emergency room)."</p> <p>***"We are not obligated to give an opinion but give facts. The family was given information that was provided by me."</p> <p>*The physician felt she was septic (life threatening infection) and was declining rapidly. "Probably multi-system failure."</p> <p>Interview on 8/19/14 at 4:05 p.m. with RN E regarding resident 1 revealed:</p> <p>***"I am unsure what days I worked with the resident from 6/17/14 to 6/20/14." (The nursing</p>	F 225			

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F 225	<p>Continued From page 13</p> <p>schedule reflected she worked the evening shift on 6/17/14 and 6/18/14.)</p> <p>*When she worked she worked on the Aspen wing, where the resident resided.</p> <p>**I think I remember hearing something that she got weak on the evening of 6/17/14."</p> <p>*She thought the CNAs had told her the resident got weak but nothing about a transfer with a mechanical lift. "I can't remember if that was the night she got weak and they went and got the Hoyer lift to transfer her."</p> <p>*Being she was unaware of the resident having problems, she was unsure how it was passed on to the next shift. It was likely the CNAs had passed it on to the next shift of CNAs.</p> <p>**It's probably something I would have charted on if I had known about it."</p> <p>**I knew she had bruises on her arms and used protective sleeves. "She always had bruising."</p> <p>**I don't remember. If something would have happened I would have reported it."</p> <p>**She was declining everyday I came. She would not eat and she would stay in bed."</p> <p>*It was her expectation with a change in a resident the CNAs would come get her.</p> <p>**She was on coumadin and bruised easily. She was weak; very weak."</p> <p>**She was total care by staff. She did not transfer on her own. She did not do anything for herself."</p> <p>Interview on 8/19/14 at 4:25 p.m. with CNA F regarding resident 1 revealed:</p> <p>*She had worked the evening of 6/19/14 and remembered the resident had stayed in her room all the time that night.</p> <p>*She did not remember transferring the resident and thought she had stayed in bed.</p> <p>*She remembered bruising around the resident's chest and thought maybe it had come from a</p>	F 225			

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F 225	<p>Continued From page 14 transfer.</p> <p>Interview on 8/20/14 at 8:00 a.m. with CNA G regarding resident 1 revealed:                      *She could not remember the dates she had worked on 6/17/14 through 6/20/14. (The nursing schedule showed she had worked the night shift on 6/18/14 and 6/19/14.)                      *The majority of the care she had provided for the resident was turning her and keeping her dry every one to two hours. She knew the last few days of her life the resident had not taken a snack during the night like she always had before. The resident would usually ask for a sandwich and a glass of milk during the night shift around 10:00 p.m. to 10:30 p.m. She had stopped asking for the snack probably two to two and one-half weeks before her death.                      *The resident never got out of bed at night, and no mechanical lift was ever used during that shift.                      *She thought she had bruising on her sides closer to her hips on both sides.                      *She remembered bruising on the sides of her chest, but not the bruises on her legs or arms.                      *Other CNAs had told her the resident's bruising had come from a lift with a transfer. No nurse had ever talked to her about the resident's bruising. "I was never given a clear answer."                      **"I was told to turn her more carefully because she had become more fragile."                      ***"She would moan out with moving her."                      **"I told the nurse she was having pain." She was unsure if the nurse had given her any pain medication.</p> <p>Phone interview on 8/20/14 at 11:00 a.m. with hospice nurse H regarding resident 1 revealed:                      *She did not do the hospice consultation on 6/19/14; hospice nurse K had.</p>	F 225		

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F 225	<p>Continued From page 15</p> <p>*She did the resident's initial hospice assessment on 6/20/14.</p> <p>*She had not documented on the resident's extensive bruising, because very shortly after her assessment the resident had died. If the resident had not died, she would have documented the extensive bruising.</p> <p>*The resident had extensive bruising on her lower legs, hip, shoulder, and breast area. She had not measured the bruising when she had done her assessment.</p> <p>*She was told by the facility the resident's bruising had happened with a transfer from a lift. She could not remember who had given her that information, a nurse or a CNA.</p> <p>*If she had been there longer she would have noted all the bruising in her documentation.</p> <p>*The resident was actively in the dying process, and the family had needed her support.</p> <p>*The resident was unresponsive. She was not moaning with repositioning.</p> <p>*She had felt the bruising was alarming. "That is why she had questioned the nursing staff. Did not feel the reason for the bruising was appropriate."</p> <p>*"The family was aware of the bruising. They had asked her if the fall had precipitated her death."</p> <p>*The family had told her they had been informed by the facility the bruising was caused by a fall with a transfer.</p> <p>*She had informed the hospice physician that had been on call of the resident's condition that included her bruising.</p> <p>Phone interview on 8/20/14 at 11:20 a.m. with hospice nurse K regarding resident 1 revealed:</p> <p>*She had done the initial hospice consultation with the resident and family on 6/19/14.</p> <p>*She had questioned the bruising on the resident's body and was told it had occurred with</p>	F 225			

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F 225	<p>Continued From page 16</p> <p>a transfer and a mechanical lift. *"The resident was tiny and frail." *She thought the family had told her she had been dropped by a lift machine. *The resident's right ribcage and right medial area had purple bruising. There also was bruising on the resident's legs. *She did not remember the resident moaning or showing any signs or symptoms of discomfort. *It did make sense someone that frail would have that kind of bruising if she had been dropped from a lift. *Someone in that frail of state any bruising would have been exaggerated.</p> <p>Interview on 8/20/14 at 12:40 p.m. with the facility's chief executive officer regarding resident 1 revealed: *They coach and teach the staff to do the right thing. They expected the physician to be informed if there were changes in a resident's condition. *He agreed there was no documentation to support how the bruising had occurred on 6/17/14 and that should have been documented by the nursing staff. *"We try and take all concerns seriously and not minimize anything." *An investigation was not done due to the resident being on coumadin and the long history of bruising easily. *Their medical director was very involved and had reviewed the resident's medical record. *He confirmed the primary physician had not documented he had been notified of the bruises, but he knew he had been. *He confirmed the above interviews and the nursing documentation had many discrepancies.</p> <p>Phone interview on 8/20/14 at 1:20 p.m. with</p>	F 225			

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F 225	<p>Continued From page 18</p> <p>infection. The family initially wanted IV fluids and antibiotics, but then decided to keep her comfortable with hospice care."</p> <p>*He had not documented in the resident's medical record the bruising and maybe should have. Due to her long history of bruising he was not overly alarmed about it as he would have been in a patient who did not have a history of bruising.</p> <p>*She had been failing for some time. Her condition deteriorated rapidly with the infection process that occurred the same time as the bruising from the transfer.</p> <p>Interview on 8/21/14 at 10:30 a.m. with CNA P regarding resident 1 revealed:</p> <p>*She had transferred the resident on the evening of 6/17/14 after supper with the stand-up lift.</p> <p>**"I'm not quite sure what to tell you about that day."</p> <p>*She had done many transfers with the resident before that day.</p> <p>*When the resident was up in the stand-up lift she had gotten weak when she was transferring her to the toilet. She sat her back down and got the nurse (not sure which nurse she got).</p> <p>*The nurse agreed since the resident was slumping it would be best to use the Hoyer lift to get her into bed.</p> <p>**"Noticed the resident had bruising on the front part of her chest, and she reported that to the nurse."</p> <p>Interview on 8/21/14 at 10:50 a.m. with RN Q regarding resident 1 revealed:</p> <p>*She was unsure what morning it had been but the night nurse told her in report (taped) that the resident became weak with a transfer. (The nursing schedule showed she worked the day shift on 6/18/14, 6/19/14, and 6/20/14.)</p>	F 225			

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F 225	Continued From page 19 *Report was taped from shift-to-shift, and she had not recalled speaking personally to the night nurse about the resident's incident. *The CNAs had reported to her the developing bruising. *The resident had no pain when she palpated the bruising on her breast. She agreed she had documented the resident had pain with palpitation. *Either myself or the medication aides give pain medications to the residents. The resident had no more pain after the assessment of the bruise had been completed. *She had talked to the DON, and it was decided the resident should now be transferred with the use of a Hoyer lift. *After she had talked to the DON about the resident "RN D took over." *She was unsure how RN D got involved except she was always willing to help the nurses on the floor. RN D would check with the nurses every morning about staffing and residents' issues. *"I assume I told RN D about the resident's bruising when she took over her care." *"RN D said she was going to call the resident's physician and family. I am not sure what she did." *She could not remember if discussion was done regarding if the resident should be evaluated in the emergency room. *"I can't tell you why RN D took over since I was the charge nurse for the resident on 6/18/14 and 6/19/14. She (RN D) just picked it up and ran with it." *"I believe the physician came and saw the resident on 6/19/14." *She had felt the bruising on the resident's breast area had a significant change on 6/19/14 when she evaluated the area with RN B from 6/18/14. *"I think RN B and I discussed having the resident	F 225			

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F 225	<p>Continued From page 20</p> <p>evaluated in the emergency room, but then RN D took over."</p> <p>*"I was not involved with the family conference on 6/19/14 at 10:30 a.m."</p> <p>*RN D was with the resident when he saw the resident on 6/19/14.</p> <p>*"I don't think RN D was involved in other residents' situations like this here before. She has worked here about six to eight months."</p> <p>*She did not think she was on duty on 6/19/14 when hospice nurse K came to see her.</p> <p>*She did not remember at any time they had asked the resident if she wanted to go to the hospital emergency room to be evaluated. It would have been a reasonable expectation to ask the resident if she was able to answer. She was not sure if RN D had asked the resident. The resident was less talkative at that time.</p> <p>*The resident had slowly been declining, but when she did go it was very rapid.</p> <p>*In the past she had usually taken care of residents' situations like that.</p> <p>*Even though she was the charge nurse on duty 6/19/14 she was not involved in the resident's care once RN D took over at about 7:00 a.m.</p> <p>Interview on 8/25/14 at 2:30 p.m. with the administrator regarding resident 1 revealed he:</p> <p>*Was aware of her unsuccessful transfer with the stand-up lift resulting in bruising to her chest.</p> <p>*Knew the nursing staff had updated the physician regarding the bruising, and the decision was made with the family to provide hospice services for her.</p> <p>*Did not feel any further investigation was necessary related to her use of coumadin and chronic problem with bruising.</p> <p>*Confirmed the nursing staff should have documented on 6/17/14 when the unsuccessful</p>	F 225			

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F 225	Continued From page 21 transfer had happened and the bruising occurred. *Stated there were some discrepancies in their documentation, and the above nursing interviews. *Left the decision up to nursing what mechanical lift should have been used for transfers. *Knew the decision had been made to change her to have been transferred with the Hoyer lift after the bruising incident.  Review of the provider's 9/8/11 Abuse policy revealed: *"To ensure that all incidents involving injuries of unknown origin are immediately called in and investigated to determine probable cause of unknown origin injuries and are reported. (There were no time parameters documented when the initial report should have been completed and when the final investigative report should have been completed." *"Supervisory personnel must report suspicion of a crime to the state survey agency by fax and at least one local law enforcement entity by fax, phone, or e-mail within a designated time frame." *"Supervisory personnel will conduct interviews of staff, resident (s), or other witness' as appropriate to the incident. Supplemental information from other parties, including date and time of the individual's awareness of the incident or suspicion of a crime, will be included with the final report." *"Corrective action based on the investigation will be completed (e.g. change of procedures, training, discipline, or discharge of staff)."	F 225			
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents.	F 226			

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F 226	<p>Continued From page 22 and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on record review, interview, and policy review, the provider failed to protect all residents from harm by ensuring: *The seven required components of abuse and neglect were addressed in their Abuse policy. *The abuse and neglect inservice training had been completed by 4 of 49 staff members (G, L, R, and U) within the twelve month requirement Findings include:</p> <p>1. Review of the provider's 9/8/11 Abuse policy revealed four components of the seven required ones of abuse and neglect had not been included: *Prevention policies and procedures. *Identification of possible incidents or allegations. *Protection of residents during investigation. *Reporting to the South Dakota Department of Health.</p> <p>2. Review of the provider's 7/1/13 through 8/29/14 training data for preventing, recognizing, and reporting resident abuse revealed: *There had been forty-nine staff members listed on the roster. *Staff members G, L, R, and U had not completed the training within the twelve month requirement. *Staff member G had last completed the inservice training on 6/19/13. She had been sixty-eight days past due for the completion requirements of that inservice.</p>	F 226	<p>F226 Facility has developed and implemented written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.</p> <p>Revised Abuse Policy to meet state and federal guidelines on 8/21/14.</p> <p>Revisions to the policy included: screening of potential employees, training of employees, prevention, identification of events, investigation, protection of residents during an investigation, and reporting/responding to appropriate agencies.</p> <p>Staff members, upon hire, are trained and given a copy of Abuse Prohibition policy. Facility has been following training guidelines outlined in regulations that stipulate training at least annually thereafter.</p>		

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F 226	Continued From page 23 *Staff member L had last completed the inservice training on 6/21/13. She had been sixty-six days past due for the completion requirements of that inservice. *Staff member R had last completed the inservice training on 7/31/13. She had been twenty-sixty days past due for the completion requirements of that inservice. *Staff member U had last completed the inservice training on 7/8/13. She had been forty-nine days past due for the completion requirements of that inservice.  Interview on 8/20/14 at 5:15 p.m. with the administrator and the director of nursing regarding the above revealed: *They were not aware the abuse policy had not contained all seven of the required components for abuse and neglect. *Their inservice training on abuse and neglect was computer generated and would have prompted the staff members on the month that inservice was to have been completed. *They had not been aware of the twelve month requirement for the completion of that annual training. *They agreed the above listed staff members had not completed their annual training as of today.	F 226	Staff members G, L, R, U had received their annual training on preventing, recognizing, and reporting abuse, but not within the 12 month time frame. As of 9/11/2014, all 49 of the staff members mentioned are in compliance of the 12 month training requirement on abuse.  Administrator and DON will audit computer generated education on the third week of each month to ensure timely completion of educational and training inservices within the 12 month requirement and report to QA monthly by Administrator/DON.  Audit will be completed monthly and ongoing and will be reported to the QA Committee until 6 months of 100% compliance is achieved. Facility's policy and practice will reflect training to occur within the 12 month period of time.		
F 279 SS=E	Refer to F225, finding 1. 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	F 279		9-20-14	

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F 279	<p>Continued From page 24</p> <p>plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, and interview, the provider failed to ensure the care plan: *Was revised, updated, and followed for two of two sampled residents (1 and 9) with an acute change in pain. *Followed goals according to the resident's wishes and non-pharmacological interventions were provided for one of one sampled resident (7) who had chronic pain. Findings include:</p> <p>1. Review of resident 1's 6/4/14 care plan revealed: **"I wish to have my pain addressed through my next review." **"Please administer pain medications per physician's orders." **"Please ask me about my pain level when you</p>	F 279	<p>F279 Facility does develop comprehensive care plans for its residents and uses the results of assessments to develop, review and revise resident's comprehensive care plan.</p> <p>Care plan policy was provided upon request while surveyors were at the facility and in addition, after leaving the facility, it was provided via fax to South Dakota Department of Health office.</p> <p>Care Plan/RAI policy was revised and expanded to include information about the care plan process, designated staff members who are involved in generating the care plan, and indicates times in which the care plan will be updated.</p>	

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F 279	<p>Continued From page 25</p> <p>are providing care to me and encourage me to report any pain that I am experiencing to staff." **"Please monitor me for signs and symptoms of pain such as grimacing, guarding, moaning, verbal complaints, and decrease in my ability to care for myself." **"Please notify my physician of any new, persistent complaints of pain, or inadequate pain control." *The above approaches had a 12/22/13 start date.</p> <p>Interview on 8/19/14 at 10:00 a.m. with the assistant director of nursing regarding resident 1 revealed: *She was responsible for coordinating and initiating the acute care plans. *She had just returned from a medical leave a few days ago and was not working 6/17/14 through 6/20/14.</p> <p>Interview on 8/19/14 at 2:30 p.m. with registered nurse Minimum Data Set/ care plan coordinator D regarding resident 1 revealed: **"Updating any acute changes would be on an acute care plan." **"The assistant director of nursing managed the acute care plans." **"The resident's pain was reviewed but not updated." **"I don't think I would say that her care plan was followed for pain on 6/18/14."</p> <p>Refer to F225, finding 1.</p> <p>2. Review of resident 9's 10/17/13 care plan revealed: **"I have potential for pain." **"I have intermittent pain related to osteoarthritis</p>	F 279	<p>Education of all nursing staff on the Care Plan/RAI policy was completed by DON at the all staff meeting held on 9/11/2014.</p> <p>The DON, along with the interdisciplinary team will audit residents care plan according to their regularly scheduled care conference. This will be reported to the QA Committee by DON or designee monthly.</p> <p>The interdisciplinary team is responsible for ensuring care plan is updated on an ongoing and as-needed basis.</p> <p>The Director of Nursing is auditing charts of residents to verify care plan is documented correctly and addressing any residents current or potential pain.</p>		

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F 279	<p>Continued From page 26 causing pain and immobility. *The above two problems had a 10/17/13 start date. **I would like to remain pain free or have pain identified as it develops and reported to the appropriate provider for treatment through my next review on 10/16/14." **I wish to have my pain addressed through my next review 10/16/14." **"Please report any verbal complaints of pain that I may have to my nurse." **"Please administer pain medications per physician's orders." **"Please ask me about my pain level when you are providing care to me and encourage me to report any pain I am experiencing to staff." **"Please monitor me for signs and symptoms of pain such as grimacing, guarding, moaning, verbal complaints, and decrease in my ability to care for myself." **"Please notify my physician of any new or persistent complaints of pain or inadequate pain control." **"Please attempt non-pharmacological interventions such as positioning for comfort as appropriate."</p> <p>Refer to F309, finding 3. Surveyor: 32355 3. Review of resident 7's 8/4/14 care plan revealed: *A problem area of potential for pain. *A goal area revealed "I would like to remain pain free or have pain identified as it develops and reported to the appropriate provider for treatment through my next review. Goal date 10/22/14." *An approach area with the following approaches listed: -"Please report any verbal complaints of pain that</p>	F 279	<p>Additionally, the Director of Nursing conducted a staff meeting to educate all professional staff and C.N.A.'s on pain control, goals, expectations, interventions, follow up and appropriate follow up in identifying the care plan on 8/27/2014.</p> <p>Care plan interventions will be reviewed and updated on an ongoing basis as dictated by the MDS schedule and as needed based on updated changes to resident's condition.</p> <p>The MDS/ADON/DON position will monitor and provide the necessary follow up to care plan, appropriate nursing personnel and/or other interventions as indicated.</p> <p>Resident 1 has since passed away so there is no further intervention put in place for this resident.</p>	

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F 279	Continued From page 27 I may have to my nurse." -"Please administer pain medications per physician orders." -"Please ask me about my pain level when you are providing care to me and encourage me to report any pain I am experiencing to staff." -"Please notify my physician of any new, persistent complaints of pain or inadequate pain control." -"Please attempt non-pharmacological interventions such as repositioning, music and relaxation techniques in conjunction with prn pain medications as appropriate."  The provider had not been able to provide a care plan policy upon request.	F 279	Resident 7's care plan was updated to include pain control goal which was established with involvement of resident, spouse, therapy and staff.  Resident 9 has since passed away so there is no further intervention put in place for this resident.	9-20-14
F 309 SS=G	Refer to F309, finding 2. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on record review, observation, and interview, the provider failed to assess, monitor, and advocate for pain management for: *One of one sampled resident (1) with documented complaints of pain related to a	F 309	F309 Facility has updated Pain Assessment and Management Policy to include comprehensive assessment and plan of care.  The goal continues to focus on providing necessary care and services to attain and/or maintain the highest practical physical, mental and psychological well being.	

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F 309	<p>Continued From page 28</p> <p>significant injury of unknown origin and acute change of condition.</p> <p>*One of one sampled resident (7) with daily complaints of chronic pain.</p> <p>*One of one sampled resident (9) exhibiting and reporting severe pain related to an acute onset and change in condition.</p> <p>Findings include:</p> <p>1. Review of resident 1's complete medical record revealed:</p> <p>*An admission date of 2/25/11.</p> <p>*A discharge date of 6/20/14.</p> <p>*The diagnoses of atrial fibrillation (irregular heart beat), Parkinson's (disease that affects movement of the body ), osteoporosis (fragile bones), and history of pulmonary embolism (blood clot).</p> <p>*She had been:</p> <p>-Taking the medications coumadin (blood thinner) and Aspirin (pain and blood thinning) daily.</p> <p>-Taking those two medications to keep her blood thin to help prevent blood clots and keep the heart rate regular.</p> <p>-Dependent upon the staff to meet all of her mobility and activities of daily living (ADL) needs.</p> <p>*She had required the use of a sit-to-stand mechanical lift (lift that required residents to be able to bear some weight on legs) and one staff member to assist her with transfers.</p> <p>*She had become weak during a transfer on 6/17/14.</p> <p>*She had her skin assessed by the skin/wound nurse B every week on Thursdays.</p> <p>*She had been alert with a (BIMS)Brief Interview of Mental Status of 11 indicating moderate memory impairment.</p> <p>*The physician had ordered hospice (comfort) services on 6/19/14.</p>	F 309	<p>Inservice was conducted by DON/Administrator on 8/27/14 with all nursing personnel to review updated policy and practice.</p> <p>Additionally, a staff meeting was conducted by DON and Administrator on 9/11/14 that included a detailed review of updated Pain Assessment and Management Policy and each nursing personnel signed as attendees.</p> <p>The attending physician of each patient is involved in assessing and addressing the appropriate follow up for remedy of pain.</p> <p>Nursing personnel have been inserviced and instructed to provide follow up charting on effectiveness of pain medication given by review and re-education of PRN medication effectiveness handout. Inservice was held on most recent staff meeting 9/11/2014.</p>		

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F 309	Continued From page 29  Review of resident 1's interdisciplinary progress notes revealed on the following: *6/18/14 from 11:30 a.m. through 10:05 p.m.: - "Received in report that res (resident) became weak during transfer with stand up lift." - "This morning res noted to have an approx (approximate) 18 x (by) 17 cm (centimeter) bruise to right under arm that extends to breast, res reported area to be TTT (tender to touch)." - The physician had been notified of the bruise with no new orders. - Did not mention that any pain medications had been administered or offered to the resident for the discomfort from the bruise.  Review of resident 1's 6/19/14 skin assessment form revealed: *She had been assessed by the skin/wound nurse B at 6:57 a.m. *The skin/wound nurse B's documentation at that time revealed: - "Blue bruises noted to bilateral shins (front of lower part of legs), purple bruises to bilateral (both) forearms, cms (circulation, motion, and sensation) altered related to right arm pain." - "Resident noted to have extensive deep, purple bruising to right axilla (armpit), right side extending to right hip and right breast with bluish bruising to sternum (chest) and 10 X 8 cm firm mass (deformity) to right upper chest." - "Resident complained of pain upon movement and palpitation (gentle touch)." - "Conferenced with day nurse regarding appearance of bruising and presence of deformity." - "Will administer pain med (medication) and f/u (follow-up) promptly." (Review of 6/19/14 medication administration record (MAR) revealed	F 309	The interdisciplinary team including the Director of Nursing, Assistant Director of Nursing, and MDS Coordinator are reviewing and assessing all residents for appropriate assessment in addressing pain that additionally includes appropriate documentation on effectiveness.  Resident Number 7's attending physician has been involved directly with patient and family on how pain medication had been ordered, and given and continues to this point, has not and will not make any changes to current schedule in place.  Current pain control goals and needs are being assessed for all residents in the facility and will be completed by 9/12/2014 with appropriate development of interventions for any pain control needs that are identified.	

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F 309	<p>Continued From page 30</p> <p>acetaminophen was administered for pain at 7:20 a.m. with no documentation if medication was effective for relieving pain).</p> <p>Review of resident 1's interdisciplinary progress notes from 6/17/14 through 6/18/14 revealed: *6/19/14 from 7:38 a.m. through 11:04 p.m.: -Laboratory (blood tests) work had been done per the physician's orders that morning. -The Minimum Data Set (MDS) nurse D documented at 3:14 p.m. she had contacted the doctor regarding the lab work results and had contacted the family regarding her condition. The physician had come to the facility to assess the resident and visit with the family at 12:45 p.m. A hospice (comfort care) consultant referral had been ordered and morphine sulfate (MS) 10 mg (milligram) every 2 hours as needed (prn) for pain. -The charge nurse documented at 11:04 p.m. the resident "is wincing during position changing however is not verbalizing pain. She does not wince when lying still. Family decided it would be ok to start the MS at this time." *No documentation to support any of the nursing staff working from 6/18/14 through 6/20/14 had asked the resident if she had been experiencing any pain.</p> <p>Review of resident 1's MAR from 6/18/14 through 6/20/14 revealed on the following: *6/18/14 she had not received nor been offered any pain medications to alleviate the discomfort from the bruise that had been identified. *6/19/14 at 9:30 p.m. revealed: -The first dose of morphine sulfate had been administered for pain. -No other documentation was found to support she had received anything after the</p>	F 309	<p>Ongoing review of resident pain control will occur according to their regularly scheduled care conference and reported to QA Committee by DON or designee monthly.</p> <p>Residents 1 and 9 have since passed away so there is no further implementation or intervention put in place for these residents.</p>	9-20-14	

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F 309	<p>Continued From page 31</p> <p>acetaminophen at 7:20 a.m. until 9:30 p.m. for pain.</p> <p>*6/20/14 at 3:45 a.m. she had received a dose of MS for pain. The effectiveness of that medication for her pain had not been documented.</p> <p>Interview on 8/19/14 at 1:35 p.m. with skin/wound nurse B regarding resident 1 confirmed:</p> <p>*Her documentation of the extensive bruising and the mass found on the resident the morning of 6/19/14.</p> <p>*She had been exhibiting pain with any movement or palpitation.</p> <p>*She had been able to visit with her during her assessment.</p> <p>*She had not asked the resident:</p> <p>-If she was experiencing any pain.</p> <p>-Where the location of the pain was.</p> <p>-If she would like anything to help stop the pain.</p> <p>Interview on 8/20/14 at 8:00 a.m. with certified nursing assistant (CNA) G regarding resident 1 revealed:</p> <p>*She had worked the night shift of 6/18/14 and 6/19/14.</p> <p>*Resident 1 had become increasingly weak and fragile when the bruising had occurred.</p> <p>*She would have turned and repositioned her every 1 to 2 hours for comfort.</p> <p>*She had to be careful with repositioning the resident as she moaned and winced with any type of movement.</p> <p>**"She was very uncomfortable."</p> <p>*She had reported the signs and symptoms of pain and discomfort to the charge nurse.</p> <p>*She could not recollect if the charge nurse had provided any pain medication to the resident.</p> <p>*The resident had never appeared to be comfortable when taking care of her.</p>	F 309			

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F 309	Continued From page 32  Interview on 8/20/14 at 10:10 a.m. with the director of nursing (DON) regarding the above record review and interviews for resident 1 revealed: * She confirmed the resident had pain upon touching the bruise. *"I think for all of us who went into see her (resident) she had been comfortable at rest." *She would have expected the nursing staff to assess and evaluate the effectiveness of any pain medication given. *No other comment had been offered by the DON for the effectiveness or management of the resident's pain by the nursing staff.  2. Review of resident 7's medical record revealed: *An admission date of 7/25/14. *Her occupation had been a nurse. *The diagnoses of Parkinson's (effects movement of the body, h/o (history of ) urinary tract infections, bacterial meningitis (swelling of the covering over the brain and spinal cord), peripheral neuropathy (nerve damage causing numbness, weakness, and pain), dementia (forgetfulness), seizures (uncontrollable body movements), and recent removal of her gallbladder. *She had required the use of a sit-to-stand mechanical lift for transfers. *She had chronic pain and had the following medications for pain control: -Lyrica (nerve pain medication) 50 mg at bedtime. -Hydrocodone (pain medication) 10/325 mg one every 6 hours prn. -Acetaminophen 500 mg every 6 hours prn. -Ibuprofen (pain medication) 400 mg every 4 hours prn.	F 309		

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F 309	Continued From page 33  Review of resident 7's 7/31/14 MDS and (CAA) care area assessment revealed: *She had required two staff members to meet all of her mobility needs. *She had been alert and oriented to person, place, and time with a BIMS score of 14 (memory intact). *Her speech was clear and could be understood by the staff. *She had rated her pain a 10 on a scale of 1 to 10 with 10 the worst pain. *She had received routine pain medications and prn pain medications/upon request during the assessment period. *"Resident with pain 10/10 at times related to recent surgery, infection, RA (arthritis), and left charot foot (neuropathy of the foot). Currently using prn and scheduled pain medications, will proceed to care plan to facilitate adequate pain control."  Review of resident 7's 8/4/14 care plan revealed: *A problem area of potential for pain. *A goal area revealed "I would like to remain pain free or have pain identified as it develops and reported to the appropriate provider for treatment through my next review. Goal date 10/22/14." *An approach area with the following interventions listed: -"Please report any verbal complaints of pain that I may have to my nurse." -"Please administer pain medications per physician orders." -"Please ask me about my pain level when you are providing care to me and encourage me to report any pain I am experiencing to staff." -"Please notify my physician of any new, persistent complaints of pain or inadequate pain	F 309			

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F 309	<p>Continued From page 34 control."</p> <p>-"Please attempt non-pharmacological [medication] interventions such as repositioning, music and relaxation techniques in conjunction [along with] with prn pain medications as appropriate."</p> <p>Review of resident 7's interdisciplinary progress notes from 7/25/14 through 8/21/14 revealed on the following:</p> <p>*7/29/14 "Resident alert and oriented x [times] 3. Verbalize to make needs known."</p> <p>*8/1/14 "Resident alert and oriented. Resident had norco [pain medication] earlier but still having some abdominal pain." No documentation to support the nurse had offered the resident anything further for pain management.</p> <p>*8/2/14 "At 11:17 a.m. resident requests room tray, stating that she did not want to go to the MDR [main dining room] due to leg pain. Resident received Tylenol [acetaminophen] at 9:00 a.m. and norco at 11:00 a.m."</p> <p>*8/4/14 "Resident states almost constant pain to abdomen and left leg that effected ability to sleep and perform day to day activities worst being 10. Resident stated that relaxation, repositioning and music may help with pain." The non-pharmacological interventions had been reviewed and added to the care plan as stated above.</p> <p>*8/5/14 "Upon further questioning, resident admits she does not want to get up because her foot hurts in the morning, and her abdomen bothers her after surgery."</p> <p>*8/11/14 "Resident states almost constant pain worst being a 9/10 effecting sleep and day to day activities with pain medication changes made during assessment period." No documentation had been found to support if those medication</p>	F 309			

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F 309	<p>Continued From page 35</p> <p>changes had been helpful.</p> <p>*No documentation found to support she had been offered anything for further pain control as stated in her care plan.</p> <p>Review of resident 7's MAR from 8/1/14 through 8/23/14 revealed:</p> <p>*She had received acetaminophen twelve times during the above time frame. The documentation of the acetaminophen revealed:</p> <p>-8/2/14 at 9:00 a.m. effectiveness charted had been "With little relief."</p> <p>-8/4/14 at 11:56 a.m. effectiveness charted had been "Tylenol did nothing."</p> <p>-8/5/14 at 11:49 a.m. effectiveness charted had been "Stated she still had a lot of pain."</p> <p>-8/7/14 at 1:50 a.m. no documentation had been found to support why the pain medication had been given or the effectiveness.</p> <p>-8/7/14 at 11:30 p.m. no documentation had been found to support why the pain medication had been given.</p> <p>*She had received Hydrocodone sixty-four times during the above time frame. The documentation of the Hydrocodone revealed:</p> <p>-The effectiveness of the pain medication had not been documented on sevevteen times.</p> <p>-She had continued to have discomfort on eleven occasions with statements of "Little relief," "Did nothing," "Still has some pain," "Resident continues to have pain," "Patient stated it did not help," "Has discomfort," "Some relief," "Relieved some pain," "Not helping much," "Stated it helped some but not much yet," "Resident stated it hasn't helped much 5/10," and "Headache gone but still has foot pain."</p> <p>*No documentation to support if she had been offered anything for further pain control.</p>	F 309			

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F 309	<p>Continued From page 36</p> <p>Interview on 8/25/14 at 10:20 a.m. with registered nurse (RN) GG regarding resident 1 revealed:</p> <ul style="list-style-type: none"> <li>*The resident had chronic pain from the peripheral neuropathy to her feet.</li> <li>*The resident was never completely pain free.</li> <li>*She was surprised the resident had not been taking more medication for neuropathy pain. The husband had declined anything further for neuropathy pain.</li> <li>*The resident had asked for pain medication every morning and evening.</li> <li>*She had offered to ask the physician for an order to put the Hydrocodone on schedule for better pain control. The husband declined and had wanted the resident to ask for the pain medications.</li> <li>*She had not documented any of the above conversations with the resident's husband.</li> </ul> <p>Interview on 8/25/14 at 1:30 p.m. with resident 7 and her husband revealed:</p> <ul style="list-style-type: none"> <li>*She had chronic pain and had taken Hydrocodone and Lyrica for years.</li> <li>*Her pain had been worse in the morning upon awakening.</li> <li>*She would have requested a pain pill from the charge nurse around 6:00 a.m.</li> <li>*On several occasions: <ul style="list-style-type: none"> <li>-She had not received that pain medication until two to three hours later.</li> <li>-The CNA would assist her with getting up without receiving any pain medications first. The CNA had informed her she needed to get up and would receive her pain medication later.</li> </ul> </li> <li>*She did not have adequate pain control nor had been free from pain.</li> <li>*She was never asked by the staff if she was having pain, where the pain was, and how much she hurt until she had asked for a pain pill.</li> </ul>	F 309			

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F 309	<p>Continued From page 37</p> <p>*She and her husband had not been involved in any conversations offering to put her pain medication on schedule for better pain control.</p> <p>*She would have preferred the pain medication to be placed on a schedule, so she did not have to request the medication.</p> <p>Interview on 8/25/14 at 2:10 p.m. with the DON revealed:</p> <p>*The resident's pain was chronic, and she had times of increase in confusion.</p> <p>*She had not "Believed there had been two to three hours between getting it (pain medication) from when the resident had asked."</p> <p>*She would not put a specific time frame on when the residents should have their pain medication given after requesting it. She stated "It would depend on the situation."</p> <p>*She expected the nurses to explain to the resident why she could not have the pain pill right away. She stated " I believe that they do."</p> <p>*She would have to review the resident in order to determine a pain control goal.</p> <p>*She expected pain control to be based on the resident's goals.</p> <p>*She would have expected the nurses to document why a pain medication had been given and the effectiveness.</p> <p>The provider had not been able to provide a Pain control policy upon request. Surveyor: 22452</p> <p>3. Review of resident 9's medical record revealed:</p> <p>*A 11/22/11 admission date.</p> <p>*Diagnoses of osteoarthritis (swelling and pain in joints),osteoporosis (weak bones), Alzheimer's disease (forgetfulness), and long-term anticoagulation use (coumadin).</p>	F 309			

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F 309	<p>Continued From page 38</p> <p>*BIMS score of 1 (indicated severe dementia [memory loss]) on the 7/16/14 MDS.</p> <p>Review of resident 9's August 2014 MAR revealed she received acetaminophen 325 mg two tablets daily upon rising in the a.m. and every four hours prn for pain or temperature.</p> <p>Review of resident 9's 8/18/14 through 8/25/14 interdisciplinary notes revealed on the following: *8/18/14 at 2:43 p.m.- "Earlier in shift staff member reported that resident had an increase in back pain. At approximately 12:30 p.m. writer to resident's side and resident denied back pain. Encouraged resident to let staff know if pain should occur. Resident reported understanding." *8/20/14 at 8:59 p.m.- "Bruising with tiny blister noted to right upper arm which she probably got from the lift. Denies pain." *8/21/14 at 6:31 a.m.- "Resident awake at 1:30 a.m. and complaining of back pain. Given two Tylenol. States helped the pain some but has not been able to get back to sleep. Finally got resident up in wheelchair and brought out to commons area to watch TV. Still awake and ready for day when night staff off duty in the a.m." **8/21/14 at 12:57 p.m.- "RN in to check bruise to right upper arm and also noted 1.0 centimeter (CM) bruise to right forearm, 2.0 cm purple bruise to left elbow, 1.5 cm purple bruise to left wrist, and (2) 1.0 cm purple bruises to bilateral shins (front of lower legs). When writer asked how they had occurred, resident states from you and points at writer. Resident then clarified and reported that her skin bruises easily just by being touched." **8/21/14 at 9:24 p.m.- "Certified nurse practitioner (CNP) here and saw resident. New order for Perform or another menthol base topical analgesic to be applied topically to affected areas,</p>	F 309		

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F 309	Continued From page 39 back and shoulder four times a day PRN for pain." *8/22/14 at 6:26 a.m.- "Resident awake by 4:30 a.m. and complaining of back pain. Offered Tylenol but resident states does not help and did not want it. Resident wanted to get out of bed so dressed. Up in wheelchair and more comfortable." *8/22/14 at 11:36 a.m.- "Resident teary eyed off and on throughout the shift. Unable to give any specific complaints or concerns but reports that she is just miserable. Denied headache, stomach ache, sore throat, or any other physical difficulties. Did report that she feels so weak. Call placed to daughter with update on order received last evening for topical analgesic. While visiting with daughter, she agreed that the resident seems to have had a decline with increased confusion at times. Writer suggested starting with a urinalysis and daughter agreed with this plan. CNP gave order at 10:55 a.m. for a straight catheter urinalysis." *8/22/14 at 4:05 p.m. by the assistant DON- "Assessed resident's transfer ability today at 12:10 p.m. this afternoon. Resident transferred from her wheelchair to the toilet in her bathroom. Resident's transfer status is posted as slide board to bed and wheelchair and Hoyer lift to the toilet. Resident demonstrates appropriate ability with use of the slide board and Hoyer lift. Resident follows directions and communicates throughout transfer process. Resident demonstrates appropriate balance and strength for this transfer designation and will remain as a slide board/Hoyer transfer status." *8/23/14 at 5:23 a.m.- "Obtained urinalysis per straight catheter. Resident tolerated well." *8/23/14 at 11:43 a.m.- "CNP gave orders to discontinue lisinopril [blood pressure medication]	F 309			

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F 309	<p>Continued From page 40</p> <p>and to monitor condition congestive heart failure [CHF]. Lisinopril was discontinued as it may be causing cough. Today resident has non pitting edema [fluid] in bilateral lower extremities. Resident reports she becomes short of breath [SOB] at times but not all the time. Lung sounds are clear throughout. Pulse oximeter [machine to check pulse and level of oxygen in blood] fluctuating between 90 percent (%) and 92% (normal greater than 90%) on room air. Weights are: -7/21/14- 100.3 pounds (lb). -7/28/14- 100.3 lb. -8/4/14- 100.4 lb. -8/11/14- 100.4 lb. -8/18/14- 101.5 lb.</p> <p>Staff reported (this was unwitnessed by writer) that resident had a coughing spell after being transferred to recliner. While assessing resident she reported that she had bilateral shoulder and back pain. Licensed practical nurse provided resident with PRN Tylenol. CNP expected in to see resident later this afternoon, update provided."</p> <p>*8/23/14 at 12:45 p.m.- "Resident slept until approximately 6:45 a.m. then assisted up to wheelchair via Hoyer and two staff members. Staff reports that while placing bra resident reported pain to bra line and especially to under bilateral scapular (shoulder) areas. Therefore bra left unfastened. Resident also reported pain to remainder of back but did report more pain to scapular regions. Applied resident with PRN analgesic cream at approximately 7:10 a.m. Approximately 45 minutes later resident reported that she thought cream had helped with pain. At 11:30 a.m. received results of urinalysis. Abnormal values noted and call placed to CNP with orders to start Amoxicillin (antibiotic) 500 mg</p>	F 309			

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F 309	Continued From page 41 three times a day for 10 days. Nurses' calendar updated to look for urinalysis culture and sensitivity on 8/25/14. Calendar also updated to offer PRN Tylenol and analgesic cream frequently related to back pain and to contact CNP/physician on 8/25/14 if back/scapular pain persists. After speaking with staff, pain may be possibly induced/associated to transfers (resident is a Hoyer at times and strap is placed around resident's bra line or resident is transferred with a slide board from recliner to wheelchair and staff assist resident with transfer by placing gait belt during the slide board transfer)." *8/23/14 at 5:28 p.m.- "Resident is not able to participate in interview with most recent BIMS score of 1. Bruises assessed today and staff interviewed for possible insight into cause. Staff note that resident self propels wheelchair in facility, and shin bruises may be related to bumping into corners of walls or other environmental challenges to resident as she navigates. Bruises to arms are possibly related to placement of arms in sling of total lift, as staff report that resident needs physical guidance to correctly position in lift sling." *8/24/14 at 1:09 p.m.- "Earlier in shift daughter and granddaughter in to see resident. They were concerned about resident's pain and audible congestion noted. Writer checked lungs and lung sounds are clear bilaterally throughout. Pulse oximeter is 93% on room air. Resident shows no signs of respiratory distress and when asked resident if she was SOB she stated she did not have a problem with breathing. Family reported her face looked fuller, this is not evident to this writer but this writer takes families opinion to heart. Resident has no edema noted to bilateral lower extremities. As of 8/21/14 resident had no significant change in weights. Family thought that	F 309			

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F 309	<p>Continued From page 42</p> <p>a complete blood count (CBC) and chest x-ray would be appropriate to rule out any respiratory problems and then to also look at resident's increased pain. Family stated that waiting for culture and sensitivity of urine would also be appropriate to ensure that bacteria is sensitive to current antibiotic and that back pain was possibly contributing to resident's urinary tract infection. Did review resident's most recent CBC which was done 7/30/14. At that time white blood cells [if elevated indicative of an infection] were within normal limits. PRN and scheduled Tylenol provided as well as analgesic cream."</p> <p>*8/25/14 at 12:24 a.m.- "Resident on antibiotic therapy with no adverse effects observed. Was medicated with Tylenol PRN."</p> <p>Observation on 8/25/14 at 10:45 a.m. of resident 9 revealed:</p> <p>*Certified nursing assistants (CNA) F and L transferred her to her recliner from her wheelchair using the Hoyer lift and a sling with an opening around her buttocks. The resident complained of pain in the right ribcage area from the sling.</p> <p>*CNAs F and L transferred her back to her wheelchair from the recliner using the Hoyer lift and the same sling. The CNAs put a gait belt around her waist and used the slide board to transfer her into bed.</p> <p>*The resident made comments of "ow" during the transfer into bed and with repositioning.</p> <p>*There was a note on the resident's head of her bed:</p> <p>-"Slide board to bed." -"Slide board to wheelchair." -"Hoyer to the toilet."</p> <p>Interview at that time with RN B who was also present during the above transfer regarding</p>	F 309		

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F 309	<p>Continued From page 43 resident 9 revealed: *The resident had her scheduled Tylenol at 6:45 a.m. *She could have Tylenol again at 10:45 a.m. *The resident had been complaining of increased back pain the past few days and was on an antibiotic for a urinary tract infection. *It was on the nurses' calendar to call the physician on her today. She had not called the physician yet.</p> <p>Interview on 8/25/14 at 12:10 p.m. with resident 9 and with RN D present revealed: *"My back hurts so bad." *The resident was coughing frequently and spitting into Kleenex and having difficulty conversing. *She was unable to rate her pain on a 1 to 10 scale (1 being little pain and 10 being severe pain) when questioned by RN D. *She stated her pain was "severe" in her back when questioned by RN D if her pain was no pain, moderate pain, or severe pain. *RN D told the resident she would take her back to her room, and they would put her into bed and give her some cough syrup.</p> <p>Observation on 8/25/14 at 12:30 p.m. of resident 9 with RNs B and D present revealed: *CNAs T and DD transferred her from her wheelchair into bed using the Hoyer lift and a full body sling. *RN B stated she had given the resident some cough syrup. She had given her Tylenol at 10:48 a.m. *RN B stated she was going to update the physician of her pain and cough.</p> <p>Interview on 8/25/14 at 12:35 p.m. with CNA DD</p>	F 309			

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F 309	<p>Continued From page 44 and RN B regarding resident 9 revealed:</p> <ul style="list-style-type: none"> <li>*They had not used the slide board to transfer her from the wheelchair to her bed because of her increased pain.</li> <li>*The decision had been made over the weekend (8/23/14 and 8/24/14) to use only the Hoyer lift for transfers due to her pain.</li> <li>*The full sling should be used with the Hoyer lift transfers as it was less painful than the sling with the buttocks exposed that she had used for toilet transfers.</li> <li>*She was unsure if all the staff had been informed of the above changes when asked why the CNAs in the morning transfer had used the slide board.</li> <li>*RN B did not comment when asked if she was aware of the transfer changes that had been made over the weekend or why the head of her bed with transfer instructions had not been changed.</li> <li>*When RN B was asked why the physician had not been notified on 8/24/14 of the family request for a CBC and chest x-ray she had no comment. Then said, she was not on duty.</li> </ul> <p>Review of resident 9's 8/18/14 through 8/25/14 MAR and PRN record revealed:</p> <ul style="list-style-type: none"> <li>*There was documentation she had received acetaminophen 325 mg two tablets every morning upon arising.</li> <li>*Acetaminophen 325 mg two tablets had been administered PRN thirteen times.</li> <li>-Eight doses of the PRN acetaminophen had no follow-up documentation as to the effectiveness of the acetaminophen on her back pain.</li> <li>-Five doses of the PRN acetaminophen had no documentation as to why it had been administered.</li> <li>-On 8/19/14 the scheduled dose of acetaminophen was documented as administered</li> </ul>	F 309		

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F 309	<p>Continued From page 45 upon arising and a PRN dose of acetaminophen was also documented as administered at 6:12 a.m.</p> <p>Review of resident 9's 8/21/14 through 8/25/14 MAR and PRN record revealed Perform or other menthol base topical analgesic cream: *Had been applied four times with documented results of some relief to relief from 8/23/14 through 8/25/14. (The physician's order on 8/21/14 revealed it could have been administered four times a day PRN). *It had not been documented as applied on 8/21/14 or 8/22/14.</p> <p>Review of resident 9's 8/25/14 at 1:00 p.m. fax sent to the physician revealed: **"SOB, cough, and expiratory wheezes with exertion." **"Facial edema noted and 1+ edema to bilateral calves." **"Confused. Leaning to right in wheelchair. Dry cough." **"Right shoulder and back severe pain." **"Poor appetite." **"Teary eyed and moans with movement." **"Weight 105.4 lb which is up 3.9 lb since 8/18/14."</p> <p>Interview on 8/25/14 at 1:30 p.m. with RN B regarding resident 9 revealed she had received orders to send the resident to the hospital emergency room via ambulance "there is no other way she could get there with her pain."</p> <p>Interview on 8/25/14 at 1:45 p.m. with the DON regarding resident 9 revealed: *Her family had agreed on 8/24/14 to wait for the urine culture and sensitivity report to come back</p>	F 309		

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F 309	Continued From page 46 after the nurse had spoken to them. *She was aware the family had requested a CBC and chest x-ray on 8/24/14. She would not have expected the nurse on duty to call the physician regarding that if they were going to wait for the culture results. *She confirmed the laminated sign on the head of her bed had not been changed when the decision had been made over the weekend to not use the slide board but only the Hoyer lift. *She confirmed the PRN acetaminophen should have had follow-up documentation if it had helped her back pain. The expectation was that PRN medications should have follow-up documentation within one to two hours. *They did not have a resident change in condition policy.	F 309		
F 323 SS=F	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: 32355 Based on observation, record review, interview, manufacturer's guidelines, and policy review, the provider failed to: *Educate all nursing staff on the use of mechanical lifts per manufacturer's guidelines. *Supervise and monitor all nursing staff for safe	F 323	F323 Facility Resident Transfer and Limited Lift Policy is in effect to ensure safety of residents and staff who provide care for them.  Facility has updated the Resident Transfer and Limited Lift Policy that includes manufacturers guidelines, safety, video if available from manufacturer, return demonstrations, regarding safe practices regarding transfers and lifts.	

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F 323	<p>Continued From page 47</p> <p>use of mechanical lifts with residents (13). *Assess and document on all residents for the safest method of transfer per facility policy and procedure. *Assess, document, and communicate change of transfer status for two of three sampled resident (1 and 9) with acute pain and change in condition. Findings include:</p> <p>1a. Observation on 8/20/14 at 1:40 p.m. of certified nursing assistant (CNA) L during a transfer revealed she had: *Entered resident 13's room and retrieved the sit-to-stand mechanical lift (lift that requires resident to be able to bear some weight on legs). *Resident 13 had been sitting on the toilet and waiting for CNA L to transfer her to her wheelchair (w/c). *CNA L: -Positioned the resident in the mechanical lift, applied the necessary sling/straps to assist her with the transfer. One of those straps went across her abdomen. -Asked the resident to hang onto the assist bars and stand while the lift was raising her up. *The strap that had gone across her abdomen became loose as the resident stood up. CNA L had not re-tightened the strap to ensure security of the resident. *CNA L positioned the resident in her w/c.</p> <p>Interview on 8/20/14 at the time of the observation with CNA L revealed: *She had been a CNA for one year. *She had been trained on the use of the mechanical lift by another CNA. *She had never been assessed by any administration to ensure she had been using the mechanical lift correctly.</p>	F 323	<p>Director of Nursing conducted the inservice on 9/11/14 to all nursing personnel and allowed for return demonstrations.</p> <p>Documentation discussions were shared with survey team on follow up nursing provided to physicians during care of resident.</p> <p>Additional training has been conducted with staff on appropriate steps and procedures to take when a resident became weak and slumped in the sit to stand lift and then was lowered to the bed for safety of resident and staff member.</p>		

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F 323	<p>Continued From page 48</p> <p>*She had not received any further education on the use of the mechanical lifts in the facility since her initial training.</p> <p>*If she had been unsure of what type of transfer a resident required she would have checked their headboard. There always should have been a small clear plastic holder attached to their headboards with a white piece of paper inside indicating the type of transfer required.</p> <p>*If the resident had not tolerated the transfer she would have sat her back down, retrieved another CNA to assist her, and reported the incident to the charge nurse.</p> <p>*The CNAs had been able to go up with a lift (sit-to-stand to a Hoyer), but they could never go back down once the type of device had been changed. They could have done that change without guidance from administration.</p> <p>*She would have been expected to report the transfer change to the charge nurse.</p> <p>*She believed therapy would have been notified and made the final determination on the type of transfer the resident required.</p> <p>*Following surveyor question about transfer: -She did not realize she should have tightened the strap around the resident's abdomen as she stood up when it loosened. -She had not recognized there had been potential for the resident to slip through the strap had she released her grip on the bars.</p> <p>b.Observation on 8/20/14 at 2:35 p.m. of NA M and CNA N during a transfer revealed: *They had prepared to assist resident 8 with a transfer from a recliner to her w/c. *They had retrieved a sit-to-stand mechanical lift and attached the appropriate sling/straps to assist her with the transfer. *Asked the resident to hang onto the assist bars</p>	F 323	<p>A competency checklist was created to assess all staff members involved in transferring residents from one surface to another to ensure proper lifting techniques per manufacturer's guidelines.</p> <p>Residents 1, 3, 7, 8, 9 and 12 along with all residents in the facility were assessed to establish the appropriate transfer designation, ensure accuracy of the transfer status posted, with documentation completed in medical record. This was completed by the DON/Administrator/MDS Coordinator.</p> <p>All residents are assessed at time of admission for transfer ability and ongoing as changes of condition develop. This is completed by the DON/designee. This will be monitored continuously and presented to QA by DON/designee monthly.</p>		

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F 323	<p>Continued From page 49 and stand while the lift was raising her up. *Positioned the resident in her w/c.</p> <p>Interview on 8/20/14 at the time of the observation with CNA N revealed: *She had been a CNA for 7 years. *She had been trained on how to use the provider's mechanical lifts at another facility she had worked at years ago. *During her training period at this facility she had been observed by another CNA to ensure she could use them properly. *She had never been assessed by any administration to ensure she had been using the mechanical lifts correctly. *She had not received any further education on the use of the mechanical lifts in the facility. *NA M was a new NA and she had been training her on the proper use of the mechanical lifts. *She had stated the same information as CNA L regarding on how to determine the proper transfer to use on all residents.</p> <p>Interview on 8/20/14 at the time of the observation with NA M revealed: *She was currently training to become a CNA. *She had received training during her course on the proper use of the mechanical lifts. *She had been working with other CNAs to ensure she understood the proper use of the mechanical lifts and transfer policy. *She had not been observed by any administration to ensure she could use the mechanical lifts correctly.</p> <p>c. Interview on 8/20/14 at 3:25 p.m. with CNA O after assisting resident 3 with a transfer into her w/c revealed: *She was a CNA II and had been a CNA for ten</p>	F 323	Residents 1 and 9 have since passed away so no further intervention to put in place for these residents.	9-20-14

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F 323	<p>Continued From page 50</p> <p>years.</p> <p>*She had received training on the proper use of the mechanical lifts years ago during her initial training to become a CNA.</p> <p>*As a CNA II she had been responsible for the training of the new CNAs on the proper use of the mechanical lifts.</p> <p>*She could not recollect the provider having inservices to ensure the staff were using the lifts properly.</p> <p>*She thought that maybe every two years the provider offered a video they could watch on the use of the lifts, but she had not been sure.</p> <p>*She confirmed the above conversations regarding the lift policy and transfer guidelines.</p> <p>*At times she would "recommend" a type of transfer for a resident, but therapy had been expected to make the final decision on a transfer change.</p> <p>d. Interview on 8/25/14 at 12:03 p.m. with CNAs R and DD after assisting resident 7 with a transfer into her recliner revealed:</p> <p>*They had both been CNAs for some time.</p> <p>*They had received training on the proper use of the mechanical lifts during their initial training period at this facility.</p> <p>*They were able to confirm the above conversations on the proper assessment and transfer guidelines from the provider's lift policy.</p> <p>*They had been responsible for the training of the new CNAs on the proper use of the mechanical lifts.</p> <p>*They could not recollect the provider having any inservices to ensure they had been using the mechanical lifts properly.</p> <p>e. Interview on 8/20/14 at 10:10 a.m. with the director of nursing (DON) revealed:</p>	F 323			

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F 323	<p>Continued From page 51</p> <p>*Her education for the CNAs on the proper use of the mechanical lifts had been random and verbal with a return demonstration at that time.</p> <p>*She had no documentation to support the CNAs had been provided with any verbal, written, or video education on the proper use of the mechanical lifts.</p> <p>*The CNA IIs had been responsible for the education and training the new CNAs and their "cohorts (peers)" beneath them.</p> <p>*She had never reviewed the manufacturer guidelines on the mechanicals lifts with the nursing staff.</p> <p>*She had recently reviewed the provider's Limited Lift policy on 5/9/14 with the CNA IIs.</p> <p>*It had been the responsibility of the CNA IIs to review this policy with the new CNAs.</p> <p>*The only follow-up she had to ensure the CNA IIs had reviewed that policy with new the CNAs was by "word of mouth."</p> <p>*The Limited Lift policy had been reviewed annually by the staff but had no documentation to support that. The staff had not been required to sign the policy after education/in-service was provided.</p> <p>Review of the provider's revised 2010 EZ (Easy) Way Stand (sit-to-stand) manufacturer's guidelines revealed "For safe operation and maximum help for your EZ Stand, watch the video training tape, read through this manual and practice on fellow staff members before using on patients [residents]."</p> <p>Review of the provider's revised 8/18/14 EZ Way Smart Lift (total lift) manufacturer's guidelines revealed "For safe operation of the EZ Way Smart Lift, operators should watch the training video, read through this manual, complete the</p>	F 323			

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F 323	<p>Continued From page 52 competency checklist, and practice on fellow staff members before use with patients."</p> <p>Interview on 8/25/14 at 2:30 p.m. with the administrator revealed the provider had no video for the nursing staff to review for safe operation of the above mechanical lifts. He had not been aware the nursing staff had not been properly trained on the use of those devices.</p> <p>Interview on 8/28/14 at 9:10 a.m. with physical therapist KK revealed: *She had been the director of rehabilitation services. *The therapists would not have given the provider direction with transfers unless the resident was on their caseload. *If the provider had problems with a transfer and requested assistance from them they would have assessed the resident and placed them on their caseload. *The nursing department had been responsible for assessing, monitoring, and determining the transfers for all of those residents not on their caseload.</p> <p>Review of the provider's undated Limited Lift policy revealed **"The resident handling policy exists to ensure a safe working environment for resident handlers. The policy is to be reviewed &amp; signed by all staff that perform or may perform resident handling. This policy will be reviewed annually with changes made accordingly." **"Initial screening will be performed on all resident to assess transfer &amp; ambulating status. This will be performed by the DON or an appointed nursing staff member." **"Resident transfer status will be reviewed via</p>	F 323			

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F 323	<p>Continued From page 53 care-plan time frame and on an as needed basis." *"There will be a transfer status assigned to each resident by the director of nursing."</p> <p>Surveyor: 22452 3. Review of the transfer status form for the facility for all fifty-two residents revealed: *Six residents had been assessed to be independent with transfers. *Twenty-six residents had been assessed to need one assist with transfers without the use of a mechanical lift. *Fifteen residents had been assessed to require the stand-up lift (mechanical lift that required the resident have the ability to bear weight on their legs) and the assistance of one staff person. *Six residents had been assessed to require the Hoyer lift (mechanical lift that did not require the resident to bear any weight on their legs) and the assistance of two staff people.</p> <p>Interview on 8/19/14 at 12:05 p.m. with the director of nursing (DON) regarding the above revealed: *The transfer ability of residents was assessed by herself, the assistant DON, and physical therapy. *Certified nursing assistants were expected to inform the nurses if a resident's transfer status changed or if the mechanical lift they were using was not tolerated by the resident. *Certified nursing assistants did not make changes in the transfer status of residents unless directed by the nurses or herself. *The residents' transfer status was on a laminated note on the headboard of their bed. The expectation of the staff was that all residents</p>	F 323			

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F 323	<p>Continued From page 54</p> <p>be transferred according to what the laminated note said.</p> <p>*If it was determined that a change was necessary in a residents' transfer status the laminated note on the head of the bed was changed.</p> <p>*They had not put how residents transferred on their care plan for some time. The residents' care plans directed the staff "For my transfer status, please refer to the transfer status posted."</p> <p>*The laminated transfer notes were kept in the assistant DON's office. If a residents' transfer status changed when nursing administration was not in the building, a charge nurse was on call who would come to the facility and change the laminated transfer note.</p> <p>*Physical therapy would usually be involved with transfer changes that were going to be permanent.</p> <p>*Residents' transfer assessments and changes were not consistently documented in the residents' medical records.</p> <p>4. Review of resident 1's 6/9/14 and 6/18/14 interdisciplinary notes revealed: *6/9/14- "Resident more weak and staff reports that Hoyer has been used later in the day." *6/18/14- "Received in report that resident became weak during transfer with stand-up lift."</p> <p>Refer to F225, finding 1.</p> <p>5. Review of resident 9's 8/22/14 interdisciplinary notes revealed: **"Assessed resident's transfer ability today at 12:10 p.m. this afternoon. Resident transferred from her wheelchair to the toilet in her bathroom. Resident's transfer status is posted as slide board to bed and wheelchair and Hoyer lift to the toilet.</p>	F 323			

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F 323	Continued From page 55 Resident demonstrates appropriate ability with use of the slide board and Hoyer lift. Resident follows directions and communicates throughout transfer process." *"Resident demonstrates appropriate balance and strength for this transfer designation and will remain as a slide board/Hoyer transfer status."	F 323			
F 490 SS=F	Refer to F309, finding 3. 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure the facility was operated and administered in a manner that ensured the safety and overall well-being for all its residents by ensuring: *Timely assessment, documentation, investigation, and reporting of resident injuries of unknown or questionable origin. *All seven of the required components of abuse and neglect were addressed in the facility Abuse policy. *All employees had reviewed the abuse inservice	F 490	F490 Facility administration has protocols and steps in place to ensure facility operates efficiently to attain and maintain the highest quality care for its residents.  Administrator has been involved in all staff inservicing/training and meetings regarding policy updates, practices at the facility and areas noted for follow up.		

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F 490	<p>Continued From page 56 annually.</p> <p>*Resident care plans had been reviewed, revised, and followed for identified residents.</p> <p>*All staff were not trained and regularly monitored in the safe use of the mechanical lifts per manufacturer's recommendations.</p> <p>*A formal process for determining and supporting any resident transfer from one surface to another. Findings include:</p> <p>1. Interview on 8/25/14 at 2:30 p.m. with the administrator revealed he had:</p> <p>*Not been aware the nursing staff had not been properly trained to use the mechanical lifts according to the manufacturer's recommendations.</p> <p>*Been aware all residents had a notification attached to their headboard indicating the type of transfer they required.</p> <p>*Not been aware who assessed, monitored, and approved the changes on transfers for all of the residents in the facility.</p> <p>*Not been aware there were no formal assessments, documentation, and policy to follow for determining and supporting any of the transfers.</p> <p>*Not been aware that four of his employees (G, L, R, and U) were late with reviewing their abuse inservice.</p> <p>*Not been aware that all seven of the required components of abuse and neglect were not addressed in their policy.</p> <p>Review of the provider's July 2012 Health Care Administrator Job Description revealed "The Health Care Services Administrator provides leadership and oversight of the Health Care facilities. This position partners with other members of the Management Team, Advisory</p>	F 490	<p>Administrator attends a variety of the ongoing meetings in the facility that includes staff meetings, stand up meetings, departmental meetings, Medicare meetings, Therapy meetings, QA meetings, Medical Director meetings, Fall and Nutritional Risk meetings, Incident review meetings and others to ensure awareness and the ability to make an impact to ensure quality care. These practices will continue.</p> <p>Administrator will continue to be part of the follow up regarding this survey and report findings to the QA Committee monthly.</p> <p>Please refer to policy revisions stated in this form:</p> <p>*Abuse Policy (F225, F226)</p> <p>*Care Plan Process (F279)</p> <p>*Pain Assessment, monitoring, management (F279,F309)</p> <p>*Mechanical Lifts (F323)</p>	

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F 490	<p>Continued From page 57</p> <p>Boards and community partners to ensure compliance with health care regulations and ensure a coordinated effort of all departments within the Health Care facilities.</p> <p>Interviews, observations, record reviews, job description review, and policy reviews throughout the course of the survey revealed the administrator had not ensured the safe management and overall well-being of the residents. Refer to F225, F226, F279, F309, and F323.</p>	F 490	<p>Items cited in this report have been corrected by:</p> <ol style="list-style-type: none"> <li>1) Policy revision</li> <li>2) Policy creation</li> <li>3) Policy implementation</li> <li>4) Staff education</li> <li>5) QA projects</li> <li>6) Evaluation of effectiveness</li> </ol> <p>To ensure compliance with state and federal guidelines through all departments in facility.</p>	9-20-14
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