

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/30/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 500 COLONIAL DRIVE SALEM, SD 57058
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F 000	INITIAL COMMENTS Surveyor: 27473 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities was conducted on 4/30/14. Areas surveyed included: quality of care and pressure ulcers, quality of life and dignity, and resident assessment. Golden LivingCenter-Salem was found not in compliance with the following requirement: F314.	F 000	<i>Addendums noted with an asterisk per email telephone to facility administrator.</i> Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. This applies to F314.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, record review, interview, and policy review, the provider failed to ensure one of four sampled residents (3) remained free from a facility-acquired pressure ulcer (injuries to skin and underlying tissues). Findings include: 1. Review of resident 3's medical record revealed: *An admit date of 9/23/13. *Diagnoses of peripheral vascular disease (problem with circulation in veins), diabetes	F 314	1. Resident 3 care plan was updated on 4/30/14 to include the presence of a pressure ulcer on his right heel and interventions to treat actual pressure ulcers. On 5/9/14 an order was obtained to discontinue the fracture boot. A skin assessment was completed on 4/30/14 for resident 3 to assess current skin condition. The Care Management team met on 5/5/14 and provided documentation to include information regarding all areas of skin concern for resident 3. All residents who have been determined to be high risk for developing pressure ulcers will have their care plan reviewed to ensure all appropriate interventions and documentation is in place by 5/17/14. 2. All residents have the potential to be effected by this practice. 3. Care management team will be educated by the director of nursing on 5/12/14 regarding the need to document the status of any alteration in skin during the care management meeting. The DON reviewed and revised as necessary the policy and procedure regarding pressure ulcer on 5/14/14 to include: Screening for pressure ulcer risk on including resident specific deficits, diagnosis and history, developing a pressure ulcer	* 05/04/14 DW/DOH/ME

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>James Meyer</i>	TITLE <i>Interim Executive Director</i>	(X6) DATE <i>5-15-14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 45 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.

APPROVED
MAY 20 2014
If continuation sheet Page of 5
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 1</p> <p>mellitus (inability to control sugar levels in the blood), peripheral neuropathy (nerve damage) in his legs, and a pressure ulcer to the left and right heels. The left heel pressure ulcer had been present prior to admission to the facility.</p> <p>*On 3/15/14 he had been sent to the emergency room (ER) for evaluation of his right lower leg for increased complaints of pain.</p> <p>*From the ER he had been given the diagnosis of a right lower extremity tibial fracture. A fracture boot had been placed on his right leg to stabilize the fracture and promote healing.</p> <p>*He had acquired a stage II pressure ulcer (shallow open area with a red/pink wound bed) on his right heel on 4/5/14.</p> <p>*The wound nurse had been monitoring the wound to his left heel weekly since admission to the facility. The wound nurse had been informed of the right heel pressure ulcer by the charge nurse on 4/5/14.</p> <p>*He had required extensive assistance of two staff members to assist him with transfers and moving in bed.</p> <p>*He had weekly skin checks by the charge nurse on Wednesday nights.</p> <p>*He received a bath weekly on Fridays.</p> <p>Review of resident 3's 4/15/14 medicare sixty day Minimum Data Set assessment revealed he had been at risk for pressure ulcers. He had required assistance with bed mobility.</p> <p>Review of resident 3's 2/14/14 care plan revealed:</p> <p>*A pressure ulcer was present on his left foot. A focus area indicated decreased mobility.</p> <p>*No documentation to support a pressure ulcer had been on his right heel.</p> <p>*No interventions to support his heels which</p>	F 314	<p>care plan and each persons role in the prevention and treatment of a pressure ulcer. Assessment and re-assessment of pressure ulcers, including a nurses role in the assessment process including the expectation that a Certified Nurse Aide's role is to report changes in a residents skin, it is a nurses role to perform the assessment. Monitoring treatment and prevention of pressure ulcers, including contacting the physician when indicated according to resident specific needs.</p> <p>Directed in-service was provided to nursing staff on 5/15/14 by the Director of Nursing regarding: Screening for pressure ulcer risk including resident specific deficits, diagnosis and history, developing a pressure ulcer care plan and each persons role in the prevention and treatment of a pressure ulcer.</p> <p>Assessment and re-assessment of pressure ulcers, including a nurses role in the assessment process including the expectation that a Certified Nurse Aide's role is to report changes in a residents skin, it is a nurses role to perform the assessment. Monitoring treatment and prevention of pressure ulcers, including contacting the physician when indicated according to resident specific needs.</p> <p>4. Director of Nursing or designee will audit 5 resident medical records to ensure that pressure ulcer presence, risk, prevention and treatment are adequately addressed on the care plan.</p> <p>Director of Nursing or designee will audit 5 resident skin assessments to ensure that they are complete and include the need to remove devices as indicated by physician order to assess for skin breakdown under the device.</p> <p>Director of Nursing or designee will audit care management meeting progress notes to ensure that all areas of skin concern specific to each</p>		

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F 314	<p>Continued From page 2 should have been floated (elevated in some manner to relieve pressure) while in bed.</p> <p>Review of resident 3's physician's orders dated 3/21/14 revealed: *"Please do regular skin checks to be certain there are no areas of skin breakdown under the fracture boot." *"The patient should wear the fracture boot at all times, but may be removed to bathe."</p> <p>Review of resident 3's weekly skin assessment sheet for 3/26/14 and 4/2/14 revealed no documentation the staff had removed his fracture boot to check for skin breakdown.</p> <p>Review of resident 3's medication and treatment administration (MAR) (TAR) records for March and April 2014 revealed no documentation the staff had removed his fracture boot to check for skin breakdown.</p> <p>Review of resident 3's nursing progress notes revealed: *From 3/17/14 through 4/4/14 there was no documentation to indicate his fracture boot had been removed for skin assessments. *On 4/5/14 the wound nurse charted a stage II pressure ulcer area to his right heel. He had refused to wear the boot as it had been rubbing on that area.</p> <p>Review of resident 3's care management meeting notes from 4/7/14 through 4/28/14 revealed no documentation to support he had a stage II pressure ulcer to his right heel. The documentation only confirmed the pressure ulcer to his left heel.</p>	F 314	<p>resident are addressed within the progress notes.</p> <p>Audits will be performed weekly for 4 weeks then monthly for 3 months</p> <p>Director of Nursing Services will report results of these audits to the monthly Quality Assessment and Process Improvement committee for review and recommendation.</p>		

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F 314	<p>Continued From page 3</p> <p>Observation on 4/30/14 at 3:20 p.m. of resident 3 revealed he had been resting in bed and lying on his back. His heels had not been floated and were lying directly on the mattress. He had no special devices in his bed to assist with pressure relieving measures for floating of his heels and repositioning.</p> <p>Interview on 4/30/14 at 3:25 p.m. with registered nurse A revealed: *She worked the evening shift. *Resident 3 would have required two to three staff members to assist him with bed mobility. *She would not have removed his fracture boot to check his skin for problems. *She would have expected the day shift staff to take care of his wounds and skin problems. *The certified nursing assistants would have removed the fracture boot and checked his skin when lotioning his legs. *She would have checked his skin if the MAR and TAR had directed her to do so. The physician would have had to order skin checks to be done for the documentation to be located on the MAR and TAR.</p> <p>Interview on 4/30/14 at 4:15 p.m. with the director of nursing revealed: *She would have expected the staff to remove his fracture boot and check his skin only on his bath day. *She stated "When residents have a cast for a broken bone we cannot remove that and check the skin, so why would I expect a fracture boot to be removed." *He received a bath once a week on Fridays. *He received weekly skin checks by the night nurse on Wednesdays. She would not have expected them to remove the boot and check for</p>	F 314		

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F 314	Continued From page 4 skin problems. *She would not have considered contacting the physician on his order dated 3/21/14 to clarify how often the fracture boot should be removed for skin checks. *She had no comment to offer when asked by this surveyor if the diagnoses resident 3 had would not justify contacting the physician for further direction. Review of the provider's 2006 Pressure Ulcer Prevention policy revealed: *The purpose was to prevent skin breakdown and development of pressure sores. *The provider was to have: -"Used an appropriate support surface in the resident's bed or chair." -"Used a pressure reducing or relieving devices as necessary." -"Positioned the residents with appropriate surfaces to protect bony prominences." -"Positioned the residents to prevent pressure from medical devices such as tubes, casts, and braces." *The care plan should have: -"Identified the appropriate problem under which to list the pressure ulcer care as an approach." -"Identified and treated the underlying cause of the pressure ulcer." -"Listed instructions unique to this resident." -"Listed necessary monitoring and observation of the underlying condition."	F 314			