

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

ORIGINAL

PRINTED: 04/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435045	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/12/2015
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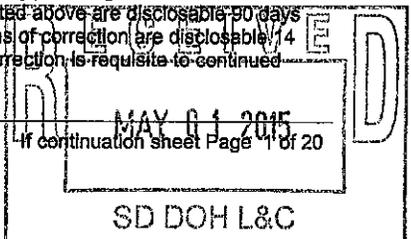
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3901 S MARION RD SIOUX FALLS, SD 57106
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F 000	INITIAL COMMENTS Surveyor: 32335 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/10/15 through 3/12/15. Areas surveyed included resident assessment, resident safety, nursing services, and physician notification. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirement(s): F151, F226, F323, and F328.	F 000	Initial Comments Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law. For the purpose of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Section 7305 of the State Operations Manual.	
F 151 SS=D	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, and record review, the provider failed to allow resident's choice in toileting for 2 of 13 residents (8 and 9) who used a bedpan. Findings include: 1. Observation and interview on 3/11/15 at 4:37 p.m. of resident 8 in her room revealed she: *Was seated in her wheelchair. *Was not bedridden. *Used the bedpan for toileting. *Had used a bedpan since her admission in October 2014. *Would have liked to have used her toilet but said	F 151		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Alicia O'Neill* TITLE *Administrator* (X6) DATE **04/09/2015**

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 151	<p>Continued From page 1 staff were unable to get the Hoyer lift into her bathroom. *Was not offered a choice on using a bedpan, commode, or toilet.</p> <p>Review of the February 2015 Minimum Data Set (MDS) assessment and current care plan for resident 8 revealed: *She needed extensive assistance of two staff for toileting according to her MDS. *Her care plan revealed she required two staff participation to use toilet. *They made no mention of using a bedpan.</p> <p>2. Observation and interview on 3/11/15 at 5:05 p.m. of resident 9 in his room revealed he: *Was seated in his electric wheelchair. *Was not bedridden. *Used the bedpan for toileting. *Had used a bedpan since his admission in October 2011. *Wanted to use the toilet, but the Hoyer lift would not fit into his bathroom. *Was told he needed to use a bedpan because of that reason. *Was not offered a choice of using a bedpan, commode, or toilet.</p> <p>Review of resident 9's medical record revealed: *He needed extensive assistance of two staff for toileting according to his 12/27/14 MDS. *His current care plan stated he preferred to use a urinal or bed pan.</p> <p>3. Interview on 3/12/15 at 1:00 p.m. with interim MDS coordinator B revealed: *Nurses would have assessed the residents to plan their best course of toileting. *She assumed they would have watched the</p>	F 151	<p>Resident 8 has been interviewed to decide what type of toileting she prefers and was added to the care plan. Resident 9 has been interviewed to decide what type of toileting he prefers and this was added to the care plan. All residents will be given the opportunity to decide the way in which they are provided toileting assistance. If a mechanical lift is used and will not fit into a bathroom, a commode will be offered as an option to the Resident. An assessment will be conducted by the nurse if a Resident or staff member identify a need for a change in toileting interventions, such as a commode, urinal or, as a last resort, a bedpan. The assessment may include an observation, interviews with staff and resident to develop a plan of care. All nursing staff will be educated on the bedpan policy and above procedure for assessments by the Director of Nursing Services. Director of Nursing Services and/or designee will review care plans, interview residents and staff to ensure residents are offered choices specifically related to toileting. The audit will be done weekly x 4 and</p>	
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F 151	Continued From page 2 resident toilet and based their decisions on that. Review of the provider's revised November 2013 Bedpan, Urinal and Commode policy revealed the purpose was to provide for the resident's needs for toileting when bedridden.	F 151	then monthly x 3. The Director of Nursing Services will forward audit results to the QAPI committee at least monthly for review.	4/10/15
F 226 SS=E	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 and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to thoroughly investigate four of four sampled residents (3, 11, 12 and 13) incident reports. Findings include: 1. Review of an initial report sent to the South Dakota Department of Health (SD DOH) on 2/10/15 regarding resident 3 revealed: *The report had been completed by licensed social worker (LSW) O. *On 2/8/15 the resident had been unresponsive throughout the day. *Staff had brought her out to the dining room for supper. *A family member had showed up for the supper meal. *The family member had yelled at a certified nursing assistant (CNA). *Another CNA stated the family member then	F 226	Unable to change the events related to Resident 3. An educational handout will be sent to all current residents' primary contact reviewing the risks and the proper way to offer nutrition. If staff observes family forcing or feeding incorrectly, they will report immediately to the Charge Nurse. Unable to change the events related to Resident 11. Staff will assist residents with preferred toileting option and return to room after call light is turned on or check on resident after a short time if resident is unable to put call light on.	

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F 226	<p>Continued From page 3</p> <p>went to the resident and force fed her a full glass of water, a resource supplement, and a bowl of "pink stuff."</p> <p>*The resident was later sent to the emergency room due to respiratory distress.</p> <p>Review of a handwritten note dated 2/8/15 with no time noted attached to the above report regarding resident 3 revealed:</p> <p>*It had been written by licensed practical nurse (LPN) N.</p> <p>*The resident had not come out of her room for supper.</p> <p>*Her family member had come to feed her at supper.</p> <p>*Since she was not in the dining room the family member "grabbed water and silverware off the table and went down the hall."</p> <p>*Five minutes later she had come back to LPN N and stated she got the resident to drink all the water.</p> <p>*LPN N went to the room, and the resident was laying flat in her bed and the family member was giving her more water through a straw.</p> <p>*The family member had not known how to raise the head of the bed.</p> <p>*LPN N showed her how to raise the head of the bed.</p> <p>*LPN N informed the family member they could not force the resident to eat.</p> <p>*The family member had requested soup and a supplement drink.</p> <p>*LPN N went back to the dining room and asked the next shift to monitor the family member.</p> <p>*Ten minutes later the family member came back into the dining room and stated she had gotten the resident to eat everything.</p> <p>Review of resident 3's medical record revealed:</p>	F 226	<p>Unable to change the events related to Resident 12. If any type of bruising is noted, staff will immediately report to the charge nurse and the charge nurse will do a complete assessment and begin the investigation.</p> <p>Unable to change the events related to Resident 13. If family or staff report mistreatment to a resident, an immediate investigation will be gin. When a resident is in pain, the nurse will assess and offer pain medication, if appropriate. When pain patch medications are found to be missing, an investigation will begin immediately.</p> <p>All incidents regarding abuse/neglect will be responded to immediately by the staff at the time of the incident.</p> <p>All staff will be educated regarding mandatory reporting and our abuse and neglect policy and procedure, including examples of potential abuse/neglect. The administrator/executive director will provide this training to the department managers who will in turn train their department staff.</p>		

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F 226	<p>Continued From page 4</p> <p>*A computerized incident report dated 2/8/15 at 8:00 p.m. and revised on 2/17/15 at 9:47 p.m.</p> <p>*That report had been completed by LPN M.</p> <p>*The report stated the following:</p> <ul style="list-style-type: none"> -She had arrived for her shift and had heard a family member in the resident's room. -For twenty minutes she heard the daughter saying "Mom you have to wake up, open your mouth, swallow, drink this, wake up and eat, you have to eat, eat." -After twenty minutes the family member approached LPN M. -LPN M entered the room and the resident was "lying flat in bed." -The family member reported she had fed her "two large mugs of water, a yogurt, and several other foods she had brought from home." -At 8:00 p.m. a medication aide had "expressed concern" to LPN M regarding the resident's health condition. -An order was received by phone from the on-call physician to send her to the emergency room at 8:30 p.m. <p>Interview and document review on 3/12/15 at 10:45 a.m. with the executive director, administrator, director of nursing (DON), and LSW O regarding resident 3 revealed:</p> <ul style="list-style-type: none"> *They were unaware why three separate descriptions of the event existed. *It was unclear if the resident had been in the dining room or in her room. *No interviews had been done regarding why no one had intervened with the family member when they knew she had been feeding the resident when she was unresponsive. *The names of the CNAs had not been listed. *There had been no other documentation regarding the investigation of the above incident. 	F 226	<p>The executive director and the rehab/skilled consultant will provide education on our abuse/neglect policy and procedure as well as how to conduct a thorough investigation to potential members of the investigation team (social workers, director of nursing services, assistant director of nursing services, admissions coordinator, medical director and administrator).</p> <p>The investigation team (DNS, Social Services, Administrator) will meet daily during the week to review incident reports and suggestion/concern forms to ensure incidents are being investigated thoroughly. A spreadsheet will be used to track reportable incidents and suggestion/concerns.</p> <p>The QAPI Coordinator or designee will audit the tracking spreadsheets to ensure incidents are being thoroughly investigated weekly x 4 and then monthly x 3. Audit findings will be forwarded by the QAPI team to the QAPI committee at least monthly.</p>	4/10/15
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F 226	<p>Continued From page 5</p> <p>*They agreed a thorough investigation had not been done to determine if neglect or abuse had occurred.</p> <p>2. Review of a 10/4/14 report made by CNA D revealed CNA C had left resident 11 on a bedpan for the second time. He had been on it for approximately two hours. The report stated his bottom was red and purple. The assistant director of nursing (ADON) at that time interviewed CNA C, and she admitted to forgetting him on the bedpan. She stated she had gotten busy. The ADON decided there had been no abuse or neglect. She stated there was no skin breakdown but had not addressed the red and purple coloring CNA D had identified. She had not questioned CNA C regarding the accusation it had happened before.</p> <p>Interview on 3/11/15 at 2:03 p.m. with CNA D regarding the above report revealed: *She had gone into see resident 11's roommate and noticed he was on the bedpan. *The resident was unable to use his call light. *He would yell, and his roommate would put on his call light for help. *She could see the skin on his bottom had a red and purple colored ring shape on it. *He had "definitely been sitting there awhile."</p> <p>Interview on 3/11/15 at 2:25 p.m. with CNA C revealed she had left resident 11 on the bedpan. She stated she had gotten busy. She had received a counseling session on the issue.</p> <p>Review of CNA C's employee file revealed there had been no documentation of the counseling session regarding the above incident.</p>	F 226			

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F 226	<p>Continued From page 6</p> <p>3. Review of a 3/4/15 initial incident report sent to the SD DOH regarding resident 12 revealed on 3/2/15 the nurse had noticed bruising around her rectal area that measured 4.5 centimeters (cm) by 5.2 cm. The resident was unsure how the bruising had occurred. The report stated it could have been from a mechanical lift used to transfer the resident. There was no documentation of interviews conducted with staff or how a lift could have caused a bruise to the rectal area. There was no further documentation that an investigation into the matter had occurred.</p> <p>4. Review of an e-mail dated 1/4/15 from a family member regarding resident 13 forwarded to LSW O revealed they had been visiting their mother that day and she had been in great pain. So much pain she had not gotten dressed that day. They informed staff that their mother had been mistreated during a shower the day before. When staff had come in that night to change the pain patch it had not been there. The family member had indicated it must have been scrubbed off in the shower the day before. She had gone without the pain patch for more then twenty-four hours, and it had been five hours since she her last pain pills.</p> <p>Review of a second e-mail from another family member on 1/6/15 regarding resident 13 revealed they had shared the same concerns as above regarding the pain patch and pain pills.</p> <p>Review of a 1/13/15 initial incident report sent to the SD DOH regarding resident 13 revealed on 1/6/15 a family member had reported that her mother had been mistreated during a shower on 1/3/15. She had indicated the staff had been rough with her mother. There was no mention of</p>	F 226			

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F 226	Continued From page 7 the missing pain patch on that report. Interviews had been conducted regarding the shower but not about the missing pain patch. The LSW had not addressed the 1/4/15 e-mail. There was no documentation an investigation into the missing pain patch had occurred. 5. Interview on 3/12/15 at 1:15 p.m. with the executive director regarding the above investigations revealed they should have been investigated more thoroughly to rule out the potential for neglect or abuse. Review of the provider's June 2014 Abuse and Neglect policy revealed: *The purpose of their policy was to ensure all identified incidents of alleged neglect or abuse were promptly investigated. *The investigation should have included interviewing staff, residents, or other witnesses to the incident. *Interview all involved individually and not as a group to help identify inconsistencies. *The LSW and other staff should have provided ongoing support and counseling to the residents and families as needed.	F 226			
F 323 SS=G	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.	F 323	Unable to change the events related to Resident 3. Staff will continue to monitor family members when they assist residents with eating. All Residents who have family members assist with eating have the potential to be affected.		

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F 323	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 32335</p> <p>A. Based on record review, interview, and policy review, the provider failed to implement interventions for one of one sampled resident (3) whose family member had forced her to eat on multiple occasions resulting in hospitalization. Findings include:</p> <p>1. Interview on 3/9/15 at 1:30 p.m. with the local ombudsman (resident advocate) from the Department of Social Services (DSS) regarding resident 3 revealed:</p> <ul style="list-style-type: none"> *On 7/9/14 a DSS worker had followed-up on a call made by the facility social worker. *The call had been entered as an adult protection services case. *The facility social worker had concerns of the daughter "force feeding" the resident. *The daughter would "slap" the resident to get her to swallow. *The daughter had not seen that as abuse. *The DSS worker had informed the facility social worker they were responsible for the resident's care. *On 7/11/14 the DSS worker had been informed by the facility the daughter was going on vacation. *The DSS worker requested the facility notify him when the daughter returned. *The facility had not followed through and the DSS adult protection services case was closed in August 2014. <p>Review of resident 3's 11/15/14 Minimum Data Set (MDS) assessment revealed she had short and long term memory problems. She needed total assistance from one staff person for eating.</p>	F 323	<p>All staff will be educated on our abuse/neglect procedure and examples of potential abuse/neglect, including inappropriate assistance with eating.</p> <p>An educational handout will be included in the admission packet that will educate families about assisting with meals, including possible risks. The staff will refer to the Medical Director to meet with a family member if additional medical input would be helpful.</p> <p>Any interventions will be added to the care plan.</p> <p>If staff have concerns while observing a family member assisting with eating, the Charge nurse or designee will educate the family member on technique and/or risks. If the family member is not compliant, the staff will intervene with the family member. A report will be made to the Department of Health and DSS and a thorough investigation will be conducted.</p>		

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F 323	<p>Continued From page 9</p> <p>Review of resident 3's 5/29/14 interdisciplinary note revealed:</p> <ul style="list-style-type: none"> *The daughter had been in the facility feeding her mother. *The daughter had been giving her drinks of fluid and prompting her to drink. *An unidentified nurse witnessed the resident's head "slump" down occasionally, and the daughter had pushed it back. *The resident had splt a few times, and the daughter had stated "Don't spit, that's not nice to spit. Come on take a drink." *The daughter would "nudge" the residents shoulder to reawaken her and to get her attention. *Two other nurses witnessed the daughter feeding the resident. *None of the nurses witnessing the daughter feed her mother in that manner had intervened. *The social worker had met with the daughter prior to the daughter leaving on vacation. *The daughter had asked staff to assist her mother with feeding. *She informed the daughter staff could not force feed the resident. *There was no documentation education had been provided to the daughter regarding the risks of force feeding her mother. <p>Review of resident 3's 6/2/14 interdisciplinary note revealed the staff had noted the physician had provided education to the daughter regarding the resident's decline.</p> <p>Review of resident 3's 6/4/14 interdisciplinary note revealed staff had spoken to the daughter about putting the resident on comfort care. She had refused. She informed the staff she had been out to the facility yesterday and got "some fluids</p>	F 323	The MDS Coordinator or designee will complete an audit weekly x 4 and then monthly x 3 in the dining room for a variety of meals to ensure a safe dining experience. The MDS Coordinator will forward the audit results to the QAPI committee at least monthly.	4/10/15	

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F 323	<p>Continued From page 10</p> <p>down [the] resident." She wanted staff to "put her head back and tell her to open wide." Staff informed the daughter they could not force feed the resident. There was no documentation that education had been provided to the daughter regarding the risks of force feeding the resident.</p> <p>Review of resident 3's 7/2/14 interdisciplinary note revealed staff had approached the daughter about the resident's pain. The daughter had refused to allow them to put her on any pain medication, but had agreed to starting hospice services as long as they would help feed her.</p> <p>Review of resident 3's 7/7/14 interdisciplinary note revealed the daughter was upset, because the staff were not making her eat. She had been at the facility over the weekend and had gotten her to eat 75-80% of her food. Staff again stated they could not force feed the resident but had not provided any education on the risks of force feeding her.</p> <p>Review of resident 3's medical record revealed her daughter had been in the facility on 2/8/15. She had forced her mother to eat when she had been unresponsive. The resident had been sent to the emergency room later that evening due to respiratory distress. Refer to F226, finding 1.</p> <p>Review of resident 3's 2/18/15 care plan revealed she needed assistance from one staff person with meals. There were no interventions listed that addressed the daughter force feeding the resident or that education to keep the resident safe had been provided to the daughter.</p> <p>Interview on 3/12/15 from 10:00 a.m. through 10:45 a.m. with the executive director,</p>	F 323			

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F 323	<p>Continued From page 11</p> <p>administrator, and the director of nursing (DON) regarding resident 3 revealed:</p> <ul style="list-style-type: none"> *They were aware the daughter had been force feeding the resident since at least 5/29/14. *They were unaware the facility social worker had contacted the local ombudsman regarding that issue in July 2014. *The facility social worker had resigned her position in September. *Licensed social worker (LSW) O had taken over for her, but they could not provide the exact date of when. *They could not find any documentation regarding the conversations with the local Ombudsman. *They were unaware if the past social worker had followed up on the Ombudsman's requests. *They had not implemented any interventions and had not educated the daughter regarding the risks of force feeding her mother. <p>Interview on 3/12/15 at 10:45 a.m. with the executive director, administrator, DON, and LSW O regarding resident 3 revealed:</p> <ul style="list-style-type: none"> *LSW O had not contacted the local Ombudsman to advocate for her. *She was unaware of what the past social worker had done for the resident. *The resident had gone into the hospital on 2/8/15 and returned on 2/13/15 with pneumonia. *She stated the daughter had discussions with a care team at the hospital and was more understanding of the risks of force feeding her mother. *LSW O had not discussed with the daughter the risks of force feeding the resident prior to her going into the hospital. *The notes listed above were the only documentation they had regarding attempted interventions. 	F 323			

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F 323	<p>Continued From page 12</p> <p>Review of the provider's June 2014 Comprehensive Care Plan and Care Conferences policy revealed: *The care plan should have been driven by identified resident issues and their unique needs. *Interventions should have been individualized, realistic and understandable.</p> <p>B. Based on observation, record review, and interview, the provider failed to identify the windows in the special care unit and in the 200, 300, and 400 hallways opened at a ninety degree angle and created a potential elopement (when a resident's location is unknown) risk. Findings include:</p> <p>1. Review of an incident report sent to the South Dakota Department of Health on 2/19/15 revealed resident 4 in the special care unit had climbed out a window and walked two blocks away.</p> <p>Observation on 3/10/15 at 7:45 p.m. in the special care unit in the room at the end of the hall on the left revealed the windows had a screen on the front held in with four plastic tabs. The window cranked out and opened to a 90 degree angle that opening was large enough for a normal sized person to get out of. The window alarm had fallen off the window.</p> <p>Interview on 3/11/15 at 4:00 p.m. with the executive director, administrator, and director of nursing revealed: *The room at the end of the hall to the left was the room resident 4 had climbed out of. *She had taken the screen off the window, opened the window, climbed on a garbage can, and then climbed out the window.</p>	F 323	<p>Unable to change the event related to Resident 4. Window alarm was secured on the window immediately by the Director of Nursing Services.</p> <p>Staff will monitor to ensure the window alarms in the special care unit are properly placed daily until changes to the windows have been made.</p> <p>The Maintenance Director contacted the contractor to adjust the windows so that they do not open to a 90 degree angle and so that a normal sized person cannot fit through the window.</p> <p>The QAPI Coordinator or designee will audit all windows to ensure the opening is the appropriate size following the adjustment of the windows. The QAPI Coordinator will forward the results of the audit to the QAPI Committee and the committee will determine if further follow up is needed.</p>	4/10/15	

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F 323	Continued From page 13 *The windows opened to a 90 degree angle. *The windows had not been on a preventative maintenance plan to check for safety. *They felt it was a fire hazard if the the windows did not open that far. *They had put the window alarms on the windows in the special care unit after resident 4 had climbed out the window. *The window alarm in that room had fallen off the window and was inactivated. *They were unsure how long it had been off the window. *They had not checked the window alarms since they had been installed after the elopement of resident 4. *They had not addressed any of the other windows in the 200, 300, or 400 hallways for safety. They also opened to a 90 degree angle.	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Surveyor: 32335	F 328	Resident 5 has had toenail care given. Nail care has been added to the resident's care plan and will be done with bath/shower care. If the resident prefers, scheduled podiatry visits will be made. Resident 1 has had toenail care given. Nail care has been added to resident's care plan. Family will be notified when podiatry appointments are made, family and resident will have the choice of nail care at the facility or with the podiatrist.		

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F 328	<p>Continued From page 14 Surveyor: 35120 Based on record review, observation, interview, and policy review, the provider failed to assess and provide adequate foot care and timely referrals to a foot doctor when requested for two of two sampled residents (1 and 5). Findings include:</p> <p>1. Review of resident 5's medical record revealed he had: *An admission date of 3/14/14. *Diagnoses of: -Parkinson's disease (uncontrollable tremors). -Heart disease. -Deep vein thrombosis (DVT [blood clot in the leg]). -High blood pressure. -Joint pain. -Chronic kidney disease stage IV (severely reduced kidney function). *A history and physical (H&P) dated 3/13/14 where the physician had said the resident had no edema (swelling) to his lower extremities.</p> <p>Review of an initial nursing admission assessment done on 3/14/14 for resident 5 revealed: *No abnormal findings of his feet. *His toenails had been documented as clean and trimmed. *No edema.</p> <p>Review of resident 5's 3/21/14 and 12/13/14 Minimum Data Set (MDS) assessments revealed: *No peripheral vascular disease (PVD [reduced blood flow to the legs]). *No kidney issues.</p> <p>Review of resident 5's 8/14/14 care plan</p>	F 328	<p>All residents will be given nail care with their bath by CNA staff. If a resident has a medical condition that prevents the CNA from providing the nail care, the licensed nurse will provide it. If the resident/family prefers or the licensed nurse is unable to provide nail care, podiatry consult will be made.</p> <p>All nursing staff will be educated on the importance of nail care for all residents by the Director of Nursing or designee. CNAs will document nail care provided. Licensed nurses will provide nail care for residents when CNAs are unable. Podiatry appointments will be made for those residents with conditions that prevent nursing staff from doing these cares.</p> <p>MDS Coordinators or designee will audit foot care on residents to assure proper nail care has been given and that nail care is documented or that podiatry services are provided weekly x 4 and then monthly x 3. Results will be forwarded to the QAPI Committee at least monthly.</p>	4/10/15	

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F 328	<p>Continued From page 15 revealed:</p> <p>*Personal hygiene tasks included: -Combing hair. -Brushing teeth. -Shaving. -Applying make-up. -Washing/drying face and hands. *There was no task for nail care.</p> <p>Review of a faxed letter to his doctor dated 3/9/15 expressed concerns about his increased edema in his legs and feet.</p> <p>Interview on 3/12/15 at 8:35 a.m. with resident 5 revealed he had: *Been at the facility for one year. *Requested to have his toenails trimmed. *Asked to see the foot doctor. *Not had his toenails trimmed since he had been admitted to the facility, and he thought they needed to be trimmed.</p> <p>Observation on 3/12/15 at 8:40 a.m. of resident 5's feet revealed his toenails on both feet were thick, long or broken off, and yellow in color.</p> <p>Interview with certified nursing assistant (CNA) E on 3/12/15 at 8:40 a.m. revealed: *Resident's toenails were to be trimmed on their bath/shower days. *There was no place in the kiosk (computer used to chart) to document that nail care had been done. *She was unaware of how staff would know if it had been completed or not. *She had never given resident 5 a bath.</p> <p>Interview with RN F on 3/12/15 at 8:50 a.m. revealed she:</p>	F 328		

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F 328	<p>Continued From page 16</p> <p>*Had been employed by the provider for the past five years. *Was unaware of when or how often nail care was performed on resident 5.</p> <p>Interview with CNA A on 3/12/15 at 9:08 a.m. revealed: *She had been employed by the provider for twenty-eight years. *She had given resident 5 a shower before. *His shower days were Sunday and Wednesday mornings. *She had not done nail care on him recently and had not known when it was done last. *There was no place to document nail care in the kiosk.</p> <p>Interview with CNA G on 3/12/15 at 9:14 a.m. revealed he: *Had been employed by the provider for six years. *Had given resident 5 a bath before and had trimmed his toenails. *Documented the nail care in the kiosk. *Did not remember the last time he had performed nail care on resident 5.</p> <p>2. Review of resident 1's medical record revealed she had: *An admission date of 7/11/14. *Diagnoses of: -High blood pressure. -Kidney disease stage III (moderate kidney damage). -Congestive heart failure (CHF [heart does not pump blood as well as it should]). -Heart disease with a history of a triple bypass (surgical heart procedure for bad veins/arteries). *An initial nursing admission assessment done on</p>	F 328			

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F 328	<p>Continued From page 17</p> <p>1/8/15 showed: -No abnormal findings of her feet. -Nails were clean and trimmed.</p> <p>Review of resident 1's 11/21/14 care plan had no mention of nail care for her. Care conference notes dated 8/8/14 through 2/27/15 had no mention of nail care or of having her see the foot doctor. She had been taken to a foot doctor outside of the facility on 12/8/14.</p> <p>Interview on 3/12/15 at 11:27 a.m. with resident 1 revealed she was unsure when her toenails were last trimmed.</p> <p>Observation on 3/12/15 at 11:33 a.m. revealed resident 1's toe nails to be trimmed, yellow in color, and thick. Some swelling was observed in her feet.</p> <p>3. Interview with CNA I on 3/12/15 at 11:29 a.m. revealed: *Residents had nail care done on their shower days. *She did not do nail care on residents who have diabetes (can not maintain blood sugar). *A foot doctor came to the facility but not very often.</p> <p>Interview with registered nurse (RN) H on 3/12/15 at 11:33 a.m. revealed: *Residents had their nail care done when they had their baths. *The activity department did nail care audits on finger nails only.</p> <p>4. Confidential interview on 3/12/15 at 2:04 p.m. with a resident's family member revealed: *The family had requested for the resident to be</p>	F 328			

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F 328	<p>Continued From page 18</p> <p>seen by a foot doctor.</p> <p>*The facility had not scheduled the resident to see the foot doctor even after the family had been told they had scheduled the resident.</p> <p>*The family ended up taking their family member to a foot doctor outside of the facility.</p> <p>*The family had not been notified about the resident seeing the foot doctor in February 2015.</p> <p>Review of the provider's resident list to see the foot doctor revealed:</p> <p>*Resident 1 had seen the facility foot care doctor on 2/4/15.</p> <p>*Resident 5 had not been on the list.</p> <p>5. Interview with the director of nursing (DON) on 3/12/15 at 2:30 p.m. revealed:</p> <p>*Residents had a choice to see the facility podiatrist or see one outside of the facility.</p> <p>*The families had to fill out a form for residents to see if they qualified to see the foot doctor.</p> <p>Review of the provider's September 2012 podiatric (foot) care policy revealed, "Residents will receive treatment by qualified person for foot disorders as well as skin and nail conditions of the feet. In addition, preventative care will be given to avoid foot problems in diabetic residents and in residents with circulatory problems."</p> <p>Review of the provider's September 2012 nail care policy revealed the purpose was to:</p> <p>*Keep nails clean and trimmed</p> <p>*Promote well being.</p> <p>*Observe the condition of the nails..</p> <p>*Help prevent nail discomfort.</p> <p>Review of the provider's September 2010 bathing policy revealed:</p>	F 328		

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F 328	Continued From page 19 *Staff were expected to assist residents with their personal care and relaxation *Step nine of the procedures stated, "Provide nail care."	F 328			