

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

ORIGINAL

PRINTED: 10/06/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/28/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702
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F 000	<p><i>*Addendums noted with an asterisk per 10/20/16 per telephone with facility administrator MPIS/DOTT/EL</i></p> <p>Surveyor: 29162 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/26/16 through 9/28/16. Golden LivingCenter-Prairie Hills was found not in compliance with the following requirements: F226, F247, F250, F274, F280, F281, F319, F441, and F514.</p>	F 000	<p>STATEMENT OF COMPLIANCE: Submission of the response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Executive Director, or there associates, agents, or other individuals who draft or may be discussed in this response and plan of correction. Preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any fact alleged or the correctness of any conclusion set forth in these allegations by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of appeal of these matters solely because of the requirement under State and Federal regulations.</p> <p><u>F226 – Develop/Implement Abuse/Neglect, ETC Policies</u></p> <p>1. Corrective action for resident(s) affected.</p>	
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, record review, interview, and policy review, the provider failed to thoroughly investigate for the potential of abuse and neglect for one of four sampled residents (8). Findings include:</p> <p>1a. Observation on 9/27/16 at 9:00 a.m. of resident 8 during a wound care treatment revealed a large amount of dark purple bruising on her back. The bruising extended from her right shoulder area down to her waist. The bruising also wrapped around to the front of her chest and abdomen. Interview with registered nurse F at that time stated it was from the standing lift sling. She had bruised due to her use of Coumadin.</p>	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10-17-16
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	<p>Continued From page 1</p> <p>Review of resident 8's interdisciplinary progress notes revealed:</p> <p>*9/11/16 at 6:01 p.m: "Bruising noted to the right side of torso, possibly from mechanical lift sling."</p> <p>*9/12/16 at 11:02 a.m: "MD contacted & updated regarding increased bruising."</p> <p>*9/15/16 at 7:08 p.m: "Physician notified of laboratory results. Physician also informed of increased bruising that radiates to chest, back and arms."</p> <p>*9/15/16 at 10:31 p.m: "Dr. came by and looked at bruising on the resident's body."</p> <p>*9/24/16 at 1:31 p.m: "Resident noted to have skin tear to left chest. Resident has bruising to chest et [and] back. Skin tear measures 4.5 cm [centimeters] et is crescent shaped." "Resident states she does not remember how it occurred. Staff states that it may have occurred during dressing this AM."</p> <p>Review of the 9/10/16 verification of investigation (VOI) report for resident 8 revealed:</p> <p>*A VOI was started on 9/10/16 at 10:46 a.m.</p> <p>*The section "Provide a detailed description of event/allegation" revealed "Resident with increased bruising noted to R breast, torso, and R arm."</p> <p>*That report assessment of the resident's injury revealed "Multiple areas of bruising to RUE [right upper extremity]. Bruising are dark purple in color. Resident denies pain when touched. Bruising noted to R breast, pattern consistent with lift sling. Resident denies pain to this area as well."</p> <p>*The investigation part of the report revealed "Resident on anticoagulant therapy. Coumadin dosage recently increased to 2 mg [milligram] on Mon & Thurs and 1.5 mg all other days. Uses standing frame lift. Bruise pattern to R breast is</p>	F 226	<p>Resident # 8 was discharged from the facility on 10/02/2016.</p> <p>2. Corrective action to identify other residents with the potential to be affected.</p> <p>All residents will be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. Residents have the right to exercise his/her resident rights. Appropriate facility staff will be re-educated on the policy/procedures for identifying and investigating abuse/neglect as outlined in section (3) below.</p> <p>3. Measures implemented to ensure deficient practice does not recur.</p> <p>The Executive Director, Director of Nursing, Interdisciplinary Team, a member of the Governing Board and the Medical Director have reviewed the Abuse and Neglect reporting and investigation policies with appropriate corrective actions taken when Abuse or Neglect is verified; Conducting Employee Background Investigation and hiring practices.</p>		

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F 226	<p>Continued From page 2 consistent with lift sling." *Recommendation taken to prevent reoccurrence was listed as "Resident may require transferring with full body lift." *Her physician was notified on 9/12/16 at 11:00 a.m. *The director of nursing (DON) was contacted on 9/12/16 at 11:00 a.m. *Her son was notified on 9/12/16 at 11:05 a.m. of the bruising. *The report was signed on 9/14/16 at 6:03 p.m. by the DON.</p> <p>*There were no noted interviews with any certified nursing assistants (CNA) regarding resident 8's bruise. *Her care plan had not been updated to include the use of the full body lift. *There was no documentation of her bruising from 9/15/16 until 9/24/16.</p> <p>Review of resident 8's weekly skin reviews revealed: *9/11/16 at 6:25 p.m: A bruise was present to the right side of her torso. *9/14/16 at 12:14 p.m: "Resident has bruising noted to right arm, breast, torso and around the back on the right side." *9/21/16 at 2:40 p.m: Old bruising to her chest, upper-mid vertebrae, front of right and left knees. *There were no measurements or descriptions of the bruising.</p> <p>b. Review of resident 8's interdisciplinary progress notes revealed on 9/24/16 at 1:31 p.m. "Resident noted to have skin tear to left chest. Resident has bruising to chest et [and] back. Skin tear measures 4.5 cm [centimeters] et is crescent shaped. Resident states she does not remember</p>	F 226	<p>All staff will be re-educated about their role and responsibilities as mandatory reporters by the Multi-Site Clinical Education Director (DCE) on October 17, 2016.</p> <p>The Interdisciplinary team (IDT) team will reeducated on the steps of the Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries, of Unknown Source and Misappropriation of Resident's Property policy by the Field Services Clinical Director on October 22, 2016.</p> <p>All Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property identified from September 28, 2016 through October 7, 2016 will be audited to assure all of the components are completed and accounted for by October 22, 2016.</p> <p>All current investigations beginning October 7, 2016 of Alleged Violations of Federal and State Laws Involving</p>	<p>*by the IDT. M.P./DOWHEL</p>

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F 226	<p>Continued From page 3 how it occurred. Staff states that it may have occurred during dressing this AM."</p> <p>Review of the 9/10/16 VOI report for resident 8 revealed: *A VOI was started on 9/24/16 at 8:30 a.m. *The section "Provide a detailed description of event/allegation" revealed "Resident noted to have 3 small dry spots of blood on upper left portion of her t-shirt following AM meal." *That report assessment of the resident's injury revealed "Upon exam resident noted to have open skin tear to left chest measuring 4.5 centimeters et crescent shaped. No s/s [signs or symptoms] of infection at site. No active bleeding noted." *Resident interview summary revealed "Resident states she does not know how skin tear occurred." *The investigation part of the report revealed "CNA staff interviewed et stated that it may have occurred during AM cares, but unsure. Unaware of origin." *The report did not state which CNAs had been interviewed. *There was no summary and outcome of investigative findings completed. *Her family was not notified. *Her physician was notified on 9/24/16 at 10:00 a.m. *The assistant director of nursing (ADON) was contacted on 9/27/16 at 4:00 p.m. *The report was signed on 9/28/16 at 10:19 a.m. by the ADON.</p> <p>Interview on 9/28/16 at 10:50 a.m. with the administrator, field services clinical director, and the ADON confirmed the above findings. They agreed the VOI investigations had not been fully</p>	F 226	<p>Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property will be completed with all components including documentation in the individual medical record of the event and follow-up and care plan review and/or revision.</p> <p>4. Additional monitoring implemented to ensure substantial compliance is maintained.</p> <p>Executive Director or designee will complete 5 targeted audits of all new Investigations weekly X 4 then Monthly X 2 to assure that interviews are conducted and documented, that the Care Plan has been reviewed and/or revised and follow-up documentation of injuries is present in the Medical Record.</p> <p>Executive Director or designee will provide the results of the audits to the Quality Assurance Performance Improvement (QAPI) committee for</p> <p><i>*three months.</i> <i>MP/SDDH/EL</i></p>	<i>10-22-16</i>	

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F 226	Continued From page 4 completed to rule out any abuse or neglect for resident 8's bruising and skin tear. Review of the provider's undated Verification of Investigation Process policy revealed: *Investigations were to be conducted per the clinical policy "Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation." *Documentation would have reflected resident assessment, record review, and that sufficient employees were interviewed to arrive at conclusion findings. Review of the provider's 9/27/16 Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source, and Misappropriation of Resident's Property policy revealed: *All investigations should have been conducted by the administrator or designee unless there was a conflict of interest. *The investigation would have included interviews of employees and residents who may have had knowledge of the alleged incident. *Factual information only should have been documented. *The provider should have made a reasonable effort to determine the cause of the alleged violation. *The director of nursing would have initiated or revised the care plan to reflect the resident's condition and measures to have been taken to prevent a recurrence.	F 226			
F 247 SS=E	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE	F 247	<u>F 247 - Right to Notice Before Room/Roommate Change</u> 1. Corrective action for resident(s) affected.		

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F 247	<p>Continued From page 5</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, interview, and policy review, the provider failed to ensure 8 of 20 residents (3, 9, 10, 11, 12, 13, 14, and 15) who had been transferred to a different room had been notified before the transfer. Findings include:</p> <p>1. Review of the provider's list of resident room-to-room transfers from 7/25/16 through 9/26/16 revealed: *Twenty residents had room changes. *Review of residents 3, 9, 10, 11, 13, and 14 revealed no documentation they or their power of attorney had been notified of their transfer from one room to another. *Resident 12 and 15's record review revealed they had been notified of the transfer after it had already occurred.</p> <p>Interview on 9/28/16 at 10:50 a.m. with the administrator, field services clinical director, and the assistant director of nursing revealed: *There had been many room-to-room moves in August and September 2016. *The moves had been done to have just one area for short-term stay residents. *They agreed there had been no documentation the eight residents had been adequately notified of the room changes.</p> <p>Review of the provider's undated Resident</p>	F 247	<p><i>* and #3 mp/soc/hls</i></p> <p>Resident # 9 will be interviewed by the Social Services Coordinator before October 17, 2016 as well as a follow-up call placed to the Power of Attorney (POA) to assure no issues are present related to the current room assignment. A corresponding progress note will be entered into the Medical Record.</p> <p>Resident # 10 was discharged from the facility on August 23, 2016 so no follow-up can be provided.</p> <p>Resident # 11 was discharged from the facility on September 21, 2016 so no follow-up can be provided.</p> <p>Resident # 12 will be interviewed by the Social Services Coordinator (SSC) before October 17, 2016 as well as a follow-up call placed to her husband to assure no issues are present related to the current room assignment. A corresponding progress note will be entered into the Medical Record.</p>		

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F 247	<p>Continued From page 5</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, interview, and policy review, the provider failed to ensure 8 of 20 residents (3, 9, 10, 11, 12, 13, 14, and 15) who had been transferred to a different room had been notified before the transfer. Findings include:</p> <p>1. Review of the provider's list of resident room-to-room transfers from 7/25/16 through 9/26/16 revealed: *Twenty residents had room changes. *Review of residents 3, 9, 10, 11, 13, and 14 revealed no documentation they or their power of attorney had been notified of their transfer from one room to another. *Resident 12 and 15's record review revealed they had been notified of the transfer after it had already occurred.</p> <p>Interview on 9/28/16 at 10:50 a.m. with the administrator, field services clinical director, and the assistant director of nursing revealed: *There had been many room-to-room moves in August and September 2016. *The moves had been done to have just one area for short-term stay residents. *They agreed there had been no documentation the eight residents had been adequately notified of the room changes.</p> <p>Review of the provider's undated Resident</p>	F 247	<p>Resident # 13 was interviewed by the Social Services Coordinator on October 11, 2016. She remains non-interviewable but she is able to nod her approval with the room when questioned by the Social Services Coordinator (SSC). Her POA was contacted on October 11, 2016 as well and had no concerns related to the current room assignment. A corresponding progress note was entered into the Medical Record on October 12, 2016 by the Social Services Coordinator (SSC).</p> <p>Resident # 14 was discharged from the facility on September 28, 2016 so no follow-up can be provided.</p> <p>Resident # 15 is not able to be interviewed so her POA was interviewed on October 12, 2016 to discuss the current room assignment and address any concerns they may have. A corresponding progress note was entered into the Medical Record by the Social Services Coordinator (SSC).</p> <p>2. Corrective action to identify other residents with the potential to be affected.</p>		

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F 247	<p>Continued From page 5</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, interview, and policy review, the provider failed to ensure 8 of 20 residents (3, 9, 10, 11, 12, 13, 14, and 15) who had been transferred to a different room had been notified before the transfer. Findings include:</p> <p>1. Review of the provider's list of resident room-to-room transfers from 7/25/16 through 9/26/16 revealed: *Twenty residents had room changes. *Review of residents 3, 9, 10, 11, 13, and 14 revealed no documentation they or their power of attorney had been notified of their transfer from one room to another. *Resident 12 and 15's record review revealed they had been notified of the transfer after it had already occurred.</p> <p>Interview on 9/28/16 at 10:50 a.m. with the administrator, field services clinical director, and the assistant director of nursing revealed: *There had been many room-to-room moves in August and September 2016. *The moves had been done to have just one area for short-term stay residents. *They agreed there had been no documentation the eight residents had been adequately notified of the room changes.</p> <p>Review of the provider's undated Resident</p>	F 247	<p>All remaining residents on the room to room transfer list which were identified during the survey will be interviewed by the Social Services Coordinator to assure there are no on-going concerns by October 22, 2016. A corresponding progress note will be entered into the Medical Record by the Social Services Coordinator (SSC).</p> <p>3. Measures implemented to ensure deficient practice does not recur.</p> <p>The Executive Director, Director of Nursing, Social Services Coordinator and the Interdisciplinary Team have reviewed and reinstated the Resident Room Relocation policy.</p> <p>All staff will be re-educated to provide each resident with sufficient time and information prior to changing the room assignment as well as Nursing staff follow-up documentation and Social Services weekly interview by the Multi-Site Clinical Education Director (DCE) on October 17, 2016.</p> <p>4. Additional monitoring implemented to ensure substantial compliance is maintained.</p>	

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F 247	Continued From page 6 Relocation Project policy revealed: *The following steps should have been taken when relocating residents: -Resident notification - Letter of intention and rationale for necessity of resident move. -Disclosure of plan - Show resident (family) room and introduce potential roommates. -Approval of plan - Permission from resident and/or family. Use of the resident relocation form. -Physically move resident - Have nursing staff document for three days any observations for the potential of changes. -Document the notification, move, and monitor for symptoms of potential adjustment issues.	F 247		
F 250 SS=G	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services 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: 26632 Based on record review, interview, and job description review, the provider failed to ensure medically necessary social services had been completed for one of one sampled resident (3) who was experiencing psychological stress regarding the death of her husband and a room change. Findings include: 1. Resident 3 had a significant loss in October 2015 with the death of her husband. She was moved from the first floor to the second floor	F 250	<u>F250 - Provision of Medically Related Social Services</u> 1. Corrective action for resident(s) affected. Resident #3 will have an interview completed by the Social Services Coordinator (SSC) by October 17, 2016 with a follow-up discussion with the responsible party to offer Psychological support services and/or weekly 1:1 visits by the SSC. A corresponding progress note will be entered into the medical record. 2. Corrective action to identify other residents with the potential to be affected.	

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F 247	Continued From page 6 Relocation Project policy revealed: *The following steps should have been taken when relocating residents: -Resident notification - Letter of intention and rationale for necessity of resident move. -Disclosure of plan - Show resident (family) room and introduce potential roommates. -Approval of plan - Permission from resident and/or family. Use of the resident relocation form. -Physically move resident - Have nursing staff document for three days any observations for the potential of changes. -Document the notification, move, and monitor for symptoms of potential adjustment issues.	F 247	Conduct Social Services review of all other residents that have had changes in condition in the past 30 days to assure that documentation of medically-related social services provided is present.		
F 250 SS=G	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services 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: 26632 Based on record review, interview, and job description review, the provider failed to ensure medically necessary social services had been completed for one of one sampled resident (3) who was experiencing psychological stress regarding the death of her husband and a room change. Findings include: 1. Resident 3 had a significant loss in October 2015 with the death of her husband. She was moved from the first floor to the second floor	F 250	3. Measures implemented to ensure deficient practice does not recur. Re-education of the Social Services Coordinator (SSC) on documentation of communications and information by the Multi-site Director of Clinical Education (DCE) on October 17, 2016. 4. Additional monitoring implemented to ensure substantial compliance is maintained. Executive Director or designee will conduct 5 random resident interviews including resident # 3, weekly X 4, monthly X 2 to ensure the residents are provided medically related social services. Executive Director or designee will provide the results of the audits to the QAPI committee for further review and recommendations. *for three months MRS. BOYD 10-22-16		

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F 250	Continued From page 7 without notification. She has had increased loss of hair and an increase in her anti-depressant medications. No interventions had been put in place to reduce her stress. Refer to F319.	F 250		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, interview, and manual review, the provider failed to determine a significant change in condition had been coded on the Minimum Data Set (MDS) assessments for one of three sampled residents (8) whose MDS assessments had been reviewed. Findings include: 1. Review of resident 8's 7/15/16 ninety-day MDS assessment revealed: *She had a brief interview for memory score of 15. That indicated she was cognitively intact.	F 274	<u>F274 - Comprehensive Assessment after Significant Change</u> 1. Corrective action for resident(s) affected. Resident # 8 was discharged from the facility on 10/02/2016 so a comprehensive significant change assessment can not be considered. 2. Corrective action to identify other residents with the potential to be affected. All current residents with Changes in Condition that are not expected to return to baseline will be reviewed during the daily Clinical meeting to assure Significant Change in Condition MDS assessments are considered. <i>*The daily meeting will be attended by the ED, DNS, ADNS, KNAC, SSC, MP/SDDOTHEL</i>	

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F 274	<p>Continued From page 8</p> <p>*She required extensive assistance from two staff to move in bed, transfer from one surface to another, use the toilet, and perform personal hygiene.</p> <p>*She required extensive assistance from one staff to move her wheelchair, dressing, and bathing.</p> <p>Review of resident 8's 9/26/16 revised care plan for fall risk interventions revealed:</p> <p>*She required assistance of one staff with transfers and toileting.</p> <p>*She was to have participated in a restorative nursing program six times a week to increase her walking distance.</p> <p>Interview on 9/27/16 at 2:40 p.m. with registered nurse C and licensed practical nurses B and D regarding resident 8 revealed:</p> <p>*She was frequently confused to time and place.</p> <p>*She was able to communicate most of her needs.</p> <p>*They had noticed a decline in the last month with her care needs.</p> <p>*She required total assistance with all of her activities of daily living.</p> <p>*She had been transferred from one surface to another using a standing lift, but was now using a total body lift.</p> <p>Interview on 9/28/16 at 10:50 a.m. with the assistant director of nursing confirmed resident 8 had a significant decline in her health and physical status. She stated the decline had been going on for more than one month.</p> <p>Interview on 9/28/16 at 10:50 a.m. with the field services clinical coordinator revealed they used the Resident Assessment instrument manual to determine when a significant change was to have</p>	F 274	<p>3. Measures implemented to ensure deficient practice will not recur.</p> <p>The Interdisciplinary team will receive education regarding the change in condition for a resident and when a comprehensive change assessment should be considered and/or completed by the Field Services Clinical Consultant on October 22, 2016.</p> <p>4. Additional monitoring implemented to ensure substantial compliance is maintained.</p> <p>The Registered Nurse Assessment Coordinator (RNAC) or designee will complete audits of 4 of the residents who have had an identified change in condition for completion of a comprehensive significant change assessment weekly X 8 and monthly X 1 to identify opportunities for Significant Change in Status (SCSA) completion.</p> <p>The RNAC or Designee will present the results of these audits to the Quality Assurance Performance Improvement (QAPI) committee monthly X 3 for further review and recommendations.</p>	10-22-16

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F 274	Continued From page 9 been completed. They did not have a specific policy. 5. Review of the 2015 Resident Assessment Instrument manual revealed: "A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not 'self-limiting' (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan."	F 274			
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	<u>F 280 - Right to participate planning Care-Revise CP</u> 1. Corrective action for resident(s) affected. Resident # 8 was discharged from the facility on 10/02/2016. 2. Corrective action to identify other residents with the potential to be affected. All current residents with changes in condition will be reviewed during the daily Clinical meeting to assure that changes in care needs are reflected in the comprehensive care plan. *ED, DNS, ADNS, RNAC, and SSC attend the clinical meeting. M/SD/DEL		

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F 280	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on interview, and record review, the provider failed to ensure care plans reflected the current status for two of six sampled residents (1 and 8). Findings include:</p> <p>1. Review of resident 8's care plan revealed: *An 11/21/13 intervention for a fall focus that she required assistance of one staff with transfers and toileting. *An 2/3/16 intervention for a fall focus that she was to have participated in a restorative nursing program six times a week to increase her walking distance. *A 4/17/11 focus area that she had a Mediport and it was to have been flushed with heparin every thirty days. *A 9/27/12 focus area that she had an indwelling urinary catheter. *A 9/26/16 intervention revision for her physical functioning focus area that she required extensive assistance of two staff for bed mobility, transfers, and toilet use.</p> <p>Interview on 9/27/16 at 2:40 p.m. with registered nurse C and licensed practical nurses B and D regarding resident 8 revealed: *They had noticed a decline in the last month with her care needs. *She required total assistance with all of her activities of daily living. *She had been transferred from one surface to another using a standing lift, but was now using a total body lift. *She did not have a Mediport.</p>	F 280	<p>3. Measures implemented to ensure deficient practice will not recur.</p> <p>Each Resident chart and care plan will be reviewed by the Interdisciplinary team within 72 hours of admission and within 24 hours of noted changes of condition including adverse events.</p> <p>All current residents' care plans will be reviewed by the Interdisciplinary Team (IDT) throughout the next quarter in an effort to ensure correct interventions are identified and implemented. <i>*to include resident #1. MP/SD/DHJ/EL</i> All licensed nurses and department heads will remain responsible for care plan revision as appropriate.. The Care Plan Policy and Procedure will be reviewed by the Interdisciplinary team.</p> <p>The care planning process will be inclusive of Facility protocols, the RAI manual, and other accepted standards of practice. Care plans will contain individualized interventions based on the individual resident needs and desires.</p>	

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F 280	Continued From page 11 *She did not have a urinary catheter. Surveyor: 29162 2. Review of resident 1's medical record revealed: *Current physician's order to "Take left wrist splint off each shift and evaluate for any skin breakdown." *There had been no mention of a left wrist splint on her entire current care plan. Interview on 9/28/16 at 10:15 a.m. with the administrator, assistant director of nurses, and the field services clinical director confirmed the current care plan for resident 1 had not been updated.	F 280	The Director of Nursing (DNS) or Designee will present the results of the audit to the monthly Quality Assurance Performance Improvement (QAPI) committee monthly for further review and recommendations.	10-27-16
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, record review, and interview, the provider failed to maintain professional nursing standards for following physicians' orders for two of six sampled residents (1 and 8). Findings include: 1. Review of resident 8's medical record revealed a 8/17/16 physician's order for an referral to Deer Oaks counseling services. Interview on 9/27/16 at 10:50 a.m. with the social services coordinator regarding resident 8	F 281	<u>F281 - Services provided meet professional standards.</u> 1. Corrective action for resident(s) affected. Resident # 8 was discharged from the facility on 10/02/2016. Resident #1 had the MD order for taking the wrist splint off each shift as well as observation of the skin discontinued on September 27, 2016. 2. Corrective action to identify other residents with the potential to be affected.	

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F 281	<p>Continued From page 12 revealed she: *Had never been seen by Deer Oaks counseling. A referral had been sent on 8/12/16, but her daughter had cancelled the referral on 8/22/16. *Agreed there was no documentation of the Deer Oaks referral or cancellation. She stated she had just called them and was given that information.</p> <p>Surveyor: 29162 2. Review of resident 1's medical record revealed: *A physician's order dated 8/12/16 to "take wrist splint off each shift and evaluate for any skin breakdown." *That same order had been on her September 2016 treatment administration record (TAR) and stated "Take wrist splint off each shift and evaluate for any skin breakdown. every shift" *Review of the September 2016 medication administration record revealed on 9/26/16 the wrist splint had been intialed as taken off and skin assessed two times. The resident had refused the assessment another time on 9/26/16.</p> <p>Observations on 9/26/16 at 1:45 p.m., 3:30 p.m., and 4:30 p.m. of resident 1 while she had been in her room revealed she did not have a splint on either wrist.</p> <p>Interview on 9/28/16 at 10:30 a.m. with the administrator, assistant director of nurses, and field services clinical director confirmed resident 1 had not been wearing a wrist splint and the documentation on her TAR had been incorrect.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013, page 350, revealed: *"The record is the most current and accurate</p>	F 281	<p>All residents with orders for Psychological services will be reviewed <i>by the IDT.</i> to ensure treatment is being provided as per the order. <i>MD/SDDOHEL</i></p> <p>Residents residing in the facility have a potential to be affected in a similar manner.</p> <p>3. Measures implemented to ensure deficient practice will not recur.</p> <p>Licensed Nursing staff will be re-educated on the Lippincott Manual of Nursing Practice page 16 for the General principles under Standards of Practice for documentation by the Multi-site Director of Clinical Education on October 17, 2016.</p> <p>DNS or designee will review nursing progress notes prior to or during clinical start up meeting to assist in identifying residents who needs have changed and provide guidance for nursing staff for notification of physician for changes in orders if necessary.</p> <p>4. Additional monitoring implemented to ensure deficient practice is corrected.</p>	

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F 281	<p>Continued From page 12 revealed she: *Had never been seen by Deer Oaks counseling. A referral had been sent on 8/12/16, but her daughter had cancelled the referral on 8/22/16. *Agreed there was no documentation of the Deer Oaks referral or cancellation. She stated she had just called them and was given that information.</p> <p>Surveyor: 29162 2. Review of resident 1's medical record revealed: *A physician's order dated 8/12/16 to "take wrist splint off each shift and evaluate for any skin breakdown." *That same order had been on her September 2016 treatment administration record (TAR) and stated "Take wrist splint off each shift and evaluate for any skin breakdown. every shift" *Review of the September 2016 medication administration record revealed on 9/26/16 the wrist splint had been intialed as taken off and skin assessed two times. The resident had refused the assessment another time on 9/26/16.</p> <p>Observations on 9/26/16 at 1:45 p.m., 3:30 p.m., and 4:30 p.m. of resident 1 while she had been in her room revealed she did not have a splint on either wrist.</p> <p>Interview on 9/28/16 at 10:30 a.m. with the administrator, assistant director of nurses, and field services clinical director confirmed resident 1 had not been wearing a wrist splint and the documentation on her TAR had been incorrect.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013, page 350, revealed: *"The record is the most current and accurate</p>	F 281	<p>*MP/SDDOHT/EL Executive Director or designee will complete 10 [REDACTED] random TAR audits to insure the treatments are being documented accurately weekly x 4 weeks and then monthly x 2 months to ensure compliance.</p> <p>Director of Nursing will report the results of the audits at the monthly QAPI meetings for further review and recommendations, *for three months.</p> <p>MP/SDDOHT/EL</p>	10-22-16
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<p>F 281</p> <p>F 319 SS=G</p>	<p>Continued From page 13 continuous source of information about a patient's [resident] health care status (350)." *"The record must describe exactly what happened to a patient and follow agency standards (350)."</p> <p>483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, interview, and job description review, the provider failed to ensure one of one sampled resident (3) with mental and psychosocial needs had those needs addressed. Findings include:</p> <p>1. Interview on 9/27/16 at 4:30 p.m. with resident 3 revealed she: *Had not been asked if she had wanted to move from her room on the first floor to the second floor. *Was still upset that she had not been given an option or notified in advance. *Stated she liked to be able to sit outside when she was on the first floor and was mad she could not do that anymore.</p> <p>Review of resident 3's medical record revealed: *She had been admitted on 10/31/11. *She had diagnoses that included Alzheimer's,</p>	<p>F 281</p> <p>F 319</p>	<p><u>F319 - Treatment/Services for Mental/Psychological Difficulties</u></p> <p>1. Corrective action for resident(s) affected.</p> <p>Resident # 3 will have an interview completed by the Social Services Coordinator (SSC) on October 17, 2016 with a follow-up discussion with the responsible party to offer Psychological support services and/or weekly 1:1 visits by the SSC. Resident #3 will have interview completed by Activities to determine an acceptable schedule for sitting outside. Documentation will correspond in the medical record.</p> <p>2. Corrective action to identify other residents with the potential to be affected.</p> <p>Conduct Social Services review of all other residents that have Physician's orders for psychological services to assure that services are being provided.</p>	
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
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F 319	Continued From page 14 glaucoma, and macular degeneration. *Her husband who had been at the same facility and had died last year. *She had been moved from the first floor to the second floor on 7/29/16. *There was no documentation she had been informed prior to that room change. *An interdisciplinary progress note on 8/9/16 at 4:39 p.m. regarding a conversation with her daughter revealed her hair was falling out in clumps. *There was no further documentation of her hair loss until 9/4/16 at 10:41 a.m. of "depression - hair loss." *An 8/9/16 fax communication was sent to her physician with an attached note from the registered nurse assessment coordinator. That note included her daughter having concerns of her hair loss. *Her physician responded on 8/9/16 with an order to decrease her "Remeron to 7.5 milligram (mg) in two weeks due to stress and move of floors." He also wrote "Stress from move most likely causing hair loss." *There was an 8/17/16 physician's order for a referral to Deer Oaks counseling services. *On 9/6/16 she and her family were notified a different room with the bed by the window was available. She was moved to that room on 9/13/16 and was very happy with the room change. *She was seen again by her physician on 9/18/16. That physician progress note included: -"Pt. [patient/resident] is stressed due to having to move from 1st to 2nd floor, with diff [different] roommate and staff. Pt is losing her hair will check TSH [thyroid function test] but most likely due to move." -She was diagnosed with	F 319	3. Measures implemented to ensure deficient practice will not recur. Reeducation of the Social Services Coordinator (SSC) regarding documentation of coordination of psychological services by the Multi-site DCE on October 17, 2016. 4. Additional monitoring implemented to ensure deficient practice is corrected. Executive Director or designee will conduct 5 random resident interviews including resident # 3, weekly X 4, monthly X 2 to ensure the residents are provided Mental/Psychosocial services. Executive Director or designee will provide the results of the audits to the QAPI committee for further review and recommendations. *for three months. 10-22-16 MP/SDR/DH/EL		

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F 319	<p>Continued From page 15</p> <p>anxiety/agitation/situational stress with significant alopecia (hair loss) from stress.</p> <p>-Physician orders on 9/19/16 included increasing her Remeron back to 15 mg and increasing her venlafaxine to 150 mg from 75 mg. She was also started on Celexa 10 mg daily for twenty-one days. Those medications were for depression.</p> <p>Review of resident 3's revised 8/9/16 care plan revealed:</p> <p>*A focus area that included "Resident has the potential to show signs and symptoms of moods and behaviors due to Dx. of Alzheimer's and Depressive disorder."</p> <p>*A goal of "Resident has baseline of 5 moods/behavior triggers per month."</p> <p>*Interventions that included:</p> <p>- "Attempt to refocus behavior to something positive when resident is upset or moody and provide reassurance as needed."</p> <p>- "Listen attentively to resident and discuss concerns with resident as needed."</p> <p>- "Social services to monitor moods and behaviors on a regular basis."</p> <p>*The care plan had not been updated since her hair had been falling out.</p> <p>*There were no interventions related to her grieving from the loss of her husband or her stress from moving.</p> <p>Interview on 9/27/16 at 10:50 a.m. with the social services coordinator (SSC) revealed she:</p> <p>*Had a previous assistant ask resident 3 if she wanted to move and she had agreed.</p> <p>*Agreed there was no documentation resident 3 had been asked about her move.</p> <p>*Had never been seen by Deer Oaks counseling. A referral had been sent on 8/12/16, but her daughter had cancelled the referral on 8/22/16.</p>	F 319		
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F 319	Continued From page 16 *Agreed there was no documentation of the Deer Oaks referral or cancellation. She stated she had just called them and had been given that information. *Agreed no interventions had been put in place for resident 3's stress related to her move. *Agreed she had not documented anything regarding the death of her spouse. *Had not reassessed her for any signs or symptoms of depression. *Agreed her previous mood interview for the 7/26/16 Minimum Data Set assessment indicated no depression. *Agreed no behaviors had been documented by staff from 7/1/16 through 9/27/16.	F 319			
F 441 SS=E	Review of the provider's 8/30/11 Social Services Coordinator job description revealed the SSC: *Would have identified and provided for each resident's social, emotional, and psychological needs. *Develop a care plan which identified pertinent problems and needs, realistic goals to be accomplished and the specific action to be taken in resolution of the problems and/or needs. *Document progress notes which would have related to each resident's care plan when necessary. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	F 441 Infection Control 1. Corrective action for resident(s) affected. Resident # 8 was discharged from the facility on 10/02/2016. Resident # 16 and # 17 have had no adverse reaction related to the wound care provided during the survey. 2. Corrective action to identify other residents with the potential to be affected.		

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F 441	<p>Continued From page 17</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review, observation, interview, and policy review, the provider failed to ensure proper infection control techniques were followed for three of three sampled residents' (8, 16, and 17) dressing changes done by one of one registered nurse (RN) (A). Findings include:</p>	F 441	<p>RN-A no longer works at the facility so we are unable to provide education on appropriate dressing changes.</p> <p>3. Measures implemented to ensure deficient practice will not recur.</p> <p>The Executive Director, Director of Nursing, Interdisciplinary Team, a member of the Governing Board, and the Medical Director have reviewed and approved the use of the GLC- clean dressing, and hand washing guidelines and/or policies.</p> <p>Licensed nursing staff will be re-educated on the procedures of completing a clean dressing change by the Multi-site Director of Clinical Education by October 17, 2016 followed by individual competency testing to be completed by October 22, 2016 or prior to their next scheduled shift in the facility.</p> <p>All staff will be re-educated in the procedure of hand washing by the Multi-site Director of Clinical Education by October 17, 2016.</p>		

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F 441	<p>Continued From page 18</p> <p>1. Review of resident 16's September 2016 treatment administration record (TAR) revealed a physician's order for wound care that stated: *"Bilateral knees, apply Aquaphor ointment daily and as needed." *"Left elbow, cleanse with normal saline and gauze, and pat dry. Apply sterile Vaseline to site and cover with Optifoam dressing."</p> <p>Observation on 9/27/16 at 11:00 a.m. of RN A while she provided a treatment for resident 16 revealed she: *Opened a garbage bag, laid it flat, and exposed the inside. *Laid her clean supplies that included gauze and saline on the opened area. *Took those supplies and garbage bag into the resident's room and laid them on his bedside table. *Washed her hands. *Put on two pairs of gloves. *Cleaned the resident's knee wounds. *Laid the soiled supplies directly on the opened garbage bag near the clean supplies. *Removed the top pair of gloves. -Provided the resident's treatment while wearing the pair of gloves that had been under the gloves she had removed. -Did not complete hand hygiene after removing the top pair of gloves. -Stated "Should I not do that?" in reference to the double gloves. *Completed the treatment to the resident's elbow. *Continued to place all used dirty supplies on the garbage bag next to the clean supplies. *Put the garbage with the used supplies in the garbage container.</p>	F 441	<p>4. Additional monitoring implemented to ensure deficient practice is corrected.</p> <p>Director of Nursing or designee will complete 5 random audits of licensed nurses clean dressing change technique, weekly x 4 weeks and then monthly x 2 months to ensure compliance, <i>*to include residents 16 on it. MP/SDDOH/EL</i> Director of Nursing or designee will complete 5 random audits of Nursing staff hand washing technique, weekly x 4 weeks and then monthly x 2 months to ensure compliance.</p> <p>Director of Nursing will report the results of the audits at the monthly Quality Assurance Performance Improvement (QAPI) meetings for further review and recommendations, <i>*for three months MP/SDDOH/EL</i></p>	<p><i>10-27-16</i></p>

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F 441	<p>Continued From page 19</p> <p>2. Review of resident 17's September 2016 TAR revealed a physician's order for wound care that stated "Right lateral head wound 1. cleanse with NS [normal saline]. 2. swab with betadine daily. 3. conservative nonexcisional debridement by WC [wound care] (Subdural matter may be exposed with aggressive debridement) 4. May leave open to air every day shift".</p> <p>Observation on 9/27/16 at 11:15 a.m. of RN A while she provided the treatment for resident 17 revealed she:</p> <ul style="list-style-type: none"> *Opened a garbage bag, laid it flat, and exposed the inside. *Laid her clean supplies that included gauze, betadine, and saline on the opened area of the bag. *Took those supplies laying on the garbage bag into the resident's room and placed them on her bedside table. *Washed her hands. *Provided the treatment for the resident. *Changed gloves without hand hygiene one time. *Continued to place all used dirty supplies on the garbage bag next to the clean supplies. *Put the garbage bag with the used supplies in the garbage container. <p>Surveyor: 26632</p> <p>3. Observation and interview on 9/27/16 at 9:00 a.m. of RN A during a dressing change for resident 8 revealed she:</p> <ul style="list-style-type: none"> *Gathered the supplies she needed for the dressing change. *Placed those clean supplies in a plastic bag and brought them into the room. *Placed the plastic bag in an open position on the arm of the recliner. *Placed a clean paper towel on the end of the 	F 441	(Intentionally blank)		

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F 441	<p>Continued From page 20</p> <p>overbed table.</p> <ul style="list-style-type: none"> *Put a small plastic medication cup with a piece of Aquacell AG on that barrier. *Washed her hands and put on gloves. *Assisted resident 8 onto her left side in the bed. *Removed her gloves and washed her hands. *Put on clean gloves. *Removed the soiled dressing, used normal saline to cleanse the wound, and put the Aquacel AG piece in the open wound. *Placed the soiled dressing and soiled Aquacel AG piece on the plastic bag next to the clean dressings. *Removed her gloves, and without sanitizing her hands put on a new pair of gloves. *Repositioned resident 8 higher up in bed. *Took the plastic bag with the soiled dressing and placed it in the garbage. *Removed her gloves and used hand sanitizer. <p>Interview with RN A at that time revealed she had not been aware she should have changed her gloves and sanitized her hands after removing the soiled dressing.</p> <p>Surveyor: 29162 Interview on 9/28/16 at 10:15 a.m. with the administrator, assistant director of nurses, and field services clinical director revealed they agreed:</p> <ul style="list-style-type: none"> *Double gloving was not acceptable. *Hand hygiene was to have been completed between gloves changes. *Clean supplies to be used and dirty supplies should not have both been placed on the garbage bag. <p>Review of the provider's last revised August 2014 Handwashing/Hand Hygiene policy revealed:</p>	F 441		
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F 441	Continued From page 21 *The facility considered hand hygiene the primary means to prevent the spread of infections. *Routine hand hygiene was to have been completed after removing gloves. *The use of gloves did not replace handwashing/hand hygiene. Review of the provider's last reviewed 2/4/16 Dressing Change, Clean policy revealed: *A plastic bag was to have placed near the foot of the bed to receive the soiled dressing. *A clean field was to have been created using paper towels or other clean barrier.	F 441			
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review, interview, and policy review, the provider failed to document: *Fall follow-up for two of two sampled residents (1 and 5) who had falls.	F 514	<u>F 514 - Clinical Records</u> 1. Corrective action for resident(s) affected. Resident # 1 remains in the facility however, we are unable to recreate progress notes regarding the post fall period. The resident has not experienced additional adverse events since August 7, 2016. Documentation will be entered into the medical record for any new event the resident experiences.		

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F 514	<p>Continued From page 22</p> <p>*Follow-up care for one of one sampled resident (5) who had concerns requiring social service intervention.</p> <p>*Notification of intended room changes for six of twenty residents (3, 9, 10, 11, 13, and 14).</p> <p>*Skin condition follow-up for one of one sampled resident (8) with skin concerns.</p> <p>*Physician ordered mental health counseling for one of one sampled resident (8).</p> <p>Findings include:</p> <p>1. Review of resident 1's medical record revealed: *An admission date of 6/17/15. *A progress note on 8/8/16 at 1:41 p.m. written by licensed practical nurse (LPN) H that stated "Resident states that she fell yesterday afternoon in doorway of her room. She did not report fall to staff et [and] got back up on her own. Fall was not witnessed by staff." *A fall follow-up progress note on 8/9/16 at 11:32 a.m. written by registered nurse (RN) C. *There had been no further documentation regarding the resident's fall. *Physician's orders had been received for a left wrist immobilizer on 8/10/16 after a visit to her physician.</p> <p>2. Review of resident 5's medical record revealed: *An admission date of 9/30/13. *A progress note on 8/15/16 at 10:05 p.m. signed by LPN D that stated "CNAs (certified nurse aide) were attempting to transfer resident from w/c to bed using lift & lift malfunctioned causing resident to fall back into w/c. Resident's upper body noted leaning against w/c [wheel chair], while his lower half was resting on CNAs legs. Sling disconnected from lift. Assistance x4 to reposition</p>	F 514	<p>Resident # 3 remains in the facility and was interviewed on September 27, 2016 by the Social Services Coordinator and she stated "The new room is good and I am enjoying the window". She is wearing hats now that she has had her hair loss with assistance in purchasing hats from her family. A progress note was entered by the Social Services Coordinator on October 12, 2016.</p> <p>Resident # 5 remains in the facility however, we are unable to recreate progress notes regarding the post fall period. The resident has not experienced additional adverse events since August 15, 2016. Documentation will be entered into the medical record for any new event the resident experiences. Resident was interviewed on September 30, 2016 regarding his desire to move rooms. The facility was unable to accommodate the request and documentation was provided in the medical record. Resident will be interviewed by October 22, 2016 by the Social Services Coordinator (SSC) and the current plan for a room accommodation will be documented in the medical record.</p>		

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F 514	<p>Continued From page 23</p> <p>resident in w/c. After successful positioning, CNA obtained another lift to transfer resident to bed. Resident denied pain/discomfort during incident. No skin abnormalities noted. VS obtained per resident's nurse: 123/57-66-97.5-20."</p> <p>*A progress note on 8/19/16 at 5:19 p.m. signed by LPN B that stated "Spoke with Dr. [name] office in r/t c/o [related to complaints os] increased pain after lift malfunctioned with him in it. Per Dr. [name] if resident would like to go to ER for evaluation we are to send. At this time resident refuses to go to ER but has the option to later if he wishes. Resident is aware of this option if he changes his mind."</p> <p>*A progress note on 8/30/16 at 1:26 p.m. signed by RN C stated "Pt states 'I want to change rooms or have my room mate change rooms. He keeps me up at night'. Notified pt that I am not aware of any open beds at this time and that I would notify social services. Pt verbalized understanding. Notified social services [name]."</p> <p>*A progress note on 9/23/16 at 5:31 p.m. signed by LPN G stated the resident did not want to change tables in the dining room. He refused to eat and returned to his room.</p> <p>*There had been no other documentation in resident 5's progress notes regarding any of the above incidents.</p> <p>3. Interview on 9/28/16 at 10:15 a.m. with the administrator, assistant director of nurses, and field services clinical director confirmed there should have been additional progress notes recorded in resident 3 and 5's medical records regarding the above events.</p> <p>4. Review of the provider's last reviewed 11/23/15 Post Fall Analysis Summary policy revealed: *A fall is a sudden change in position usually</p>	F 514	<p>Resident # 8 was discharged from the facility on 10/02/2016.</p> <p>Resident # 9 will be interviewed by the Social Services Coordinator before October 17, 2016 as well as a follow-up call placed to the Power of Attorney (POA) to assure no issues are present related to the current room assignment. A progress note will be entered into the medical record.</p> <p>Resident # 10 was discharged from the facility on August 23, 2016 so no follow-up can be provided.</p> <p>Resident # 11 was discharged from the facility on September 21, 2016 so no follow-up can be provided.</p> <p>Resident # 13 was interviewed by the Social Services Coordinator on October 11, 2016. She remains non-interviewable but she is able to nod her approval with the room. Her POA was contacted on October 11, 2016 as well and had no concerns related to the current room assignment. A progress note was entered by the Social Services Coordinator on October 12, 2016.</p>		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/28/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
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F 514	<p>Continued From page 24 involving the floor.</p> <p>*"Nurses Note/Interventions: Summarize the significant assessment findings, actions taken to treat injuries, the resident's response to the treatment, and interventions that were in place at the time of the fall."</p> <p>*"3. "Ongoing assessments including neurological, and pain alert charting documentation shall occur according to facility policy.</p> <p>Surveyor: 26632</p> <p>5. Review of the provider's list of resident room-to-room transfers from 7/25/16 through 9/26/16 revealed:</p> <p>*Twenty residents had room changes.</p> <p>*Review of residents 3, 9, 10, 11, 13, and 14's medical records revealed no documentation they or their power of attorney had been notified of their transfer from one room to another.</p> <p>6. Review of resident 8's interdisciplinary progress notes revealed:</p> <p>*9/11/16 at 6:01 p.m: "Bruising noted to the right side of torso, possibly from mechanical lift sling."</p> <p>*9/12/16 at 11:02 a.m: "MD contacted & updated regarding increased bruising."</p> <p>*9/15/16 at 7:08 p.m: "Physician notified of laboratory results. Physician also informed of increased bruising that radiates to chest, back and arms."</p> <p>*9/15/16 at 10:31 p.m: "Dr. came by and looked at bruising on the resident's body."</p> <p>*9/24/16 at 1:31 p.m: "Resident noted to have skin tear to left chest. Resident has bruising to chest et [and] back. Skin tear measures 4.5 cm [centimeters] et is crescent shaped." "Resident states she does not remember how it occurred. Staff states that it may have occurred during</p>	F 514	<p>Resident # 14 was discharged from the facility on September 28, 2016 so no follow-up can be provided.</p> <p>2. Corrective action to identify other residents with the potential to be affected.</p> <p>Residents residing in the facility have the potential to be affected in a similar manner.</p> <p>3. Measures implemented to ensure deficient practice will not recur.</p> <p>Documentation education will be provided to all Licensed Nurses and members of the Interdisciplinary team (IDT) by the multi-site Director of Education (DCE) on October 17, 2016.</p> <p>4. Additional monitoring implemented to ensure deficient practice is corrected.</p> <p>The Director of Nursing (DNS) or designee will audit 10 Resident charts weekly X 4 weeks and monthly X 2 months to assure the Medical Records are complete.</p>		

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F 514	<p>Continued From page 25 dressing this AM." *There was no documentation of her bruising from 9/15/16 until 9/24/16. *There was no documentation of her skin tear after 9/24/16.</p> <p>7. Review of resident 8's medical record revealed a 8/17/16 physician's order for an referral to Deer Oaks counseling services.</p> <p>Interview on 9/27/16 at 10:50 a.m. with the social services coordinator regarding resident 8revealed she: *Had never been seen by Deer Oaks counseling. A referral had been send on 8/12/16, but her daughter had canceled the referral on 8/22/16. *Agreed there was no documentation of the Deer Oaks referral or cancellation. She stated she had just called them and had been given that information.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013, page 350, revealed: *"The record is the most current and accurate continuous source of information about a patient's [resident] health care status (350)." *"The record must describe exactly what happened to a patient and follow agency standards (350)."</p>	F 514	<p>The Director of Nursing (DNS) or designee will report the results of the audits monthly X 3 months to the Quality Assurance Performance Improvement (QAPI) committee further review and recommendations.</p>	10-22-16	