

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

ORIGINAL

PRINTED: 08/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/14/2013
NAME OF PROVIDER OR SUPPLIER ABERDEEN HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 12218 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/13/13 through 8/14/13. Aberdeen Health and Rehab was found not in compliance with the following requirements: F164, F224, F281, F282, F329, F368, F371, F431, and F441.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when	F 164	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states with respect to: 1. Residents #23, #24 and #25 receive administered insulin in a private area. All other residents will receive insulin in a private area. If the resident refuses the nurse will document. 2. All clip boards have been removed and confidential information has been placed in binder and the binder is placed in a roll top desk on the unit. The MARS are kept closed unless staff members are present.	

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

TITLE

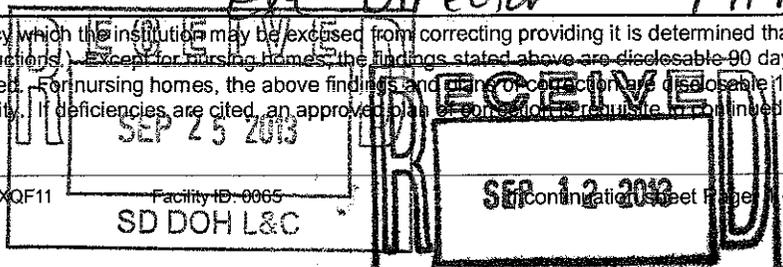
(X6) DATE

Megan Kleinsasser

Eve Director

9-11-13

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 plan 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 the linked program participation.



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F 164	<p>Continued From page 1</p> <p>release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to ensure privacy and confidentiality of residents' information was maintained for: *Posted information in one of three neighborhoods (Birchwood). *Medication administration records (MAR) left open during three random observations. *Three of three observations of residents (23, 24, and 25) insulin administration in public areas. Findings include:</p> <p>1. Observation on 8/13/13 at 10:15 a.m. in the dining room of the Birchwood neighborhood revealed: *A posted sheet of paper on the bulletin board in the lower right-hand corner of the board labeled Resident Fluid and Consistency Restrictions stating: -Resident names with room numbers and directions on fluid restrictions, thickened liquids, NPO (nothing by mouth of food or fluid). *On a clipboard on top of a desk a sheet of paper labeled Birchwood vitals stating: -Resident names and room numbers with blood pressure, pulse, temperature, respiration, and oxygen saturation, daily weights, and falls. *Seven residents, one employee, and one other surveyor were present at the above time and place. *The area was used by residents and visitors who</p>	F 164	<p>3. By September 11th, 2013 all nursing staff will be educated on maintaining privacy of information and privacy/confidentiality when receiving medications or treatments.</p> <p>4. The DNS and/or her designee will audit for compliance of maintaining confidentiality and privacy of MARS/TARS, confidential information found in the binders, and administering insulin 3 times per week for two months and then 2 times a week for 1 month for all residents on insulin.</p> <p>5. The data collected will be presented to the QA committee by the DNS. The data will be reviewed/discussed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies.</p> <p>6. The DNS is responsible for this area of compliance.</p> <p><i>MAR 9-23-13</i></p>	10/03/2013	

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F 164	<p>Continued From page 2</p> <p>would have been able to view the above listed residents' confidential information.</p> <p>Observation on 8/13/13 at 4:21 p.m. in the dining room of the Birchwood neighborhood revealed: *A posted sheet of paper on the bulletin board with the same information as that listed above. *On a clipboard on top of a desk a sheet of paper labeled Monthly BM (bowel movement) Charting with a handwritten Birchwood and August 2013 stating: -Residents' names. -Days of the month with the a listing of D (day), E (evening), and N (night). -A numbering system for the amount of the bowel movement. -A numbering system for the appearance of the bowel movement. *Six residents and one employee were present at the above time and place. *The area was used by residents and visitors who would have been able to view the above listed residents' confidential information.</p> <p>Observation on 8/13/13 at 5:25 p.m. and on 8/14/13 at 8:07 a.m. in the dining room of the Birchwood neighborhood revealed the same information as listed above.</p> <p>Interview and observation on 8/14/13 at 9:50 a.m. in the dining room of the Birchwood neighborhood with the social services designee revealed: *The above posted residents' lists were confidential. *The posted information "should not be in that place." *The information needed to be in a confidential location. *The resident information was in an area viewed</p>	F 164		

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F 164	<p>Continued From page 3 by visitors and guests.</p> <p>Review of the provider's undated Notice of Privacy Practices policy revealed: "Protected Health Information (PHI)- Information that is a subset of health information, including demographic information, and 1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse, and 2. Relates to the past, present, or future physical or mental health or condition of an individual the provision of health care to an individual; and a. That identifies the individual; or b. There is a reasonable basis to believe the information can be used to identify the individual."</p> <p>Surveyor: 32572 2. Observation of residents' medication administration records (MAR) revealed they had been left open to resident confidential information and unattended by staff on: *8/13/13 at 8:39 a.m. on cart two on Country Lane with other residents within the area. *8/13/13 at 12:00 noon in the Birchwood dining room during the medication pass. During that time there were residents around the area of the medication cart. *8/13/13 from 4:39 p.m. through 5:10 p.m. on cart two on Country Lane. Residents, visitors, the maintenance supervisor, and three unidentified CNAs had been in the area at that time.</p> <p>Interview on 8/14/13 at 10:00 a.m. with the director of nursing (DON) confirmed she would have expected the MAR to have been closed when staff had not been with it.</p> <p>3. Observation on 8/13/13 at 5:20 p.m. revealed licensed practical nurse E administered insulin to</p>	F 164		

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F 164	<p>Continued From page 4</p> <p>resident 25 in the television lounge area on Country Lane. Other residents were in the same area at that time.</p> <p>Interview 8/14/13 at 10:00 a.m. with the DON confirmed she would have expected the insulin to have been given in a private area.</p> <p>Surveyor: 29164</p> <p>Observation on 8/13/13 at 4:30 p.m. revealed registered nurse (RN) B:</p> <p>*Administered an insulin injection in the arm of resident 23 while the resident stood by the medication cart in the sitting area of the rehabilitation unit. *Other residents had been seated on couches and in wheel chairs in that area and resident 23 had been visible to them.</p> <p>*Administered an insulin injection in the abdomen of resident 24 while the resident sat in her wheel chair in the sitting area of the rehabilitation unit. *Other residents had been seated on couches and in wheel chairs in that area and resident 24 had been visible to them.</p> <p>Interview on 8/15/13 at 9:30 a.m. with the DON revealed she would have expected the insulin to have been administered to residents in a private area where the injection would not have been witnessed by others.</p> <p>Review of the provider's November 2002 Insulin Administration policy and procedures manual revealed no instruction for staff to administer insulin privately unless the resident and those around the resident did not object to watching the injection.</p>	F 164		
F 224	483.13(c) PROHIBIT	F 224	See next page	

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F 224 SS=E	<p>Continued From page 5</p> <p>MISTREATMENT/NEGLECT/MISAPPROPRIATN</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: 32335 Based on observation, interview, and policy review, the provider failed to use interventions to prevent an agitated environment for 4 of 11 residents (3, 14, 27, and 28) in the memory support unit (Birchwood Court). Findings include:</p> <p>1. Observation on 8/13/13 at 10:30 a.m. in Birchwood Court revealed: *Resident 3 came up behind resident 14 and started to push her wheelchair into the kitchen area where the floor had just been mopped. *Resident 14 could not see behind her and attempted to stop the movement by putting her feet down. *Medication technician G and the nurse consultant watched resident 3 push resident 14. *The nurse consultant stated to be careful as to not bump her elbow. *Resident 14 appeared upset with the movement as she tried to stop being pushed forward. *Staff had not intervened between the residents. *Medication technician G had informed this surveyor earlier in the morning resident 14 did not like resident 3 and would become agitated around him.</p>	F 224	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states with respect to:</p> <ol style="list-style-type: none"> 1. Resident #3 was seen by his physician for evaluation on 8-26-13 and medications have been adjusted and target behaviors/interventions were added to MAR/TAR. Resident #14 and #28 have been assessed and target behaviors/interventions have been added to MAR/TAR. Resident #27 was placed on contact precautions on 8-13-13 for infectious disease. Target behaviors/interventions for resident #27 as well as activities while on contact precautions will be care planned and audited. 2. All residents are assessed and interventions/target behaviors are added to MAR/TAR when necessary. 	
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F 224	<p>Continued From page 6</p> <p>2. Observation on 8/13/13 at 12:30 p.m. regarding residents 3 and 28 revealed: *Resident 3 had wheeled up to resident 28's table and was speaking to another resident at the table. *Resident 28 became agitated and stated to the resident that resident 3 had been talking to "just slap him, just slap him." *Resident 28 became increasingly agitated and stated two different times to resident 3 "come over here and I will punch you." *Staff had not intervened during that exchange.</p> <p>3. Observation on 8/13/13 at 5:00 p.m. in Birchwood Court revealed: *Certified nursing assistant (CNA) C had been wearing a mask over his mouth and nose. *He walked up to resident 27 and asked her to put a mask on. *Resident 27 appeared to be confused and became agitated the more CNA C asked her to wear a mask. *CNA C had continued to ask her to put a mask on. *Resident 27 had attempted to move away from him by scooting in her wheelchair, but he stood in front of her. *Resident 27 became so agitated she had attempted to get out an exit door at the end of the hallway.</p> <p>Interview on 8/13/13 immediately following the above observation with medication technician G regarding resident 27 revealed: *She had a confirmed case of Methicillin resistant staphylococcus aureus or MRSA (a difficult to treat infection) in her nose. *She had returned from the hospital on 8/12/13.</p>	F 224	<p>3. By September 11th, 2013 all nursing staff will be educated on resident Target Behaviors/Interventions. The RN Nurse Educator presented a synopsis from "CMS Hand in Hand" video on ways to intervene when residents are placed in difficult situations.</p> <p>4. The DNS and/or her designee will audit residents 3, 14, 27, 28 and all those with behaviors on Birchwood court.</p> <p>5. The data collected will be presented to the QA committee by the DNS. The data will be reviewed/discussed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies.</p> <p>6. The DNS is responsible for this area of compliance.</p> <p><i>ML 9-27-13</i></p>
			10/03/2013

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F 224	<p>Continued From page 7</p> <p>*She was to stay in her room or wear a mask to prevent the spread of MRSA. *She had been out of her room approximately 20-25 times that day without wearing a mask. *If resident 27 remained agitated she would give her an as needed (PRN) medication to calm her down. *Medication technician G could not state what interventions from her care plan she was to attempt prior to giving her medication to calm her.</p> <p>Interview on 8/13/13 at 5:30 p.m. with the director of nursing (DON) and the nurse consultant revealed they were not aware of the specific situation occurring with resident 27. They thought she had just returned today, and she had been on antibiotics (medications used to treat infections) for the MRSA. They were not sure if the MRSA could have been spread at that time or what precautions should have been taken for residents, staff, or visitors.</p> <p>4. Interview on 8/14/13 at 7:30 a.m. with the DON and the nurse consultant revealed: *Resident 27 had returned to the facility on 8/12/13. *The DON had not been notified of her return. *Resident 27 had not started on antibiotics until her return to the facility. *They were currently not taking any precautions regarding the MRSA and had not asked resident 27 to wear a mask. *Giving a PRN medication after CNA C had agitated resident 27 was not what should have happened. *They did not have an answer on what should have been done regarding all the above observations.</p>	F 224		
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F 224	Continued From page 8 Review of the provider's 12/11/11 Abuse, Neglect, and Misappropriation of Property Prevention Policy revealed: *They had a zero tolerance policy that included any person, patient, or visitor that was on the property. *Employees were to identify, intervene, and correct any situations in which abuse or neglect might occur. *Patients/residents were to be continuously assessed, care planned, and monitored in order to identify needs and behaviors which may lead to conflict or neglect.	F 224		
F 281 SS=E	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: 32335 Based on observation, record review, interview, and policy review, the provider failed to ensure: *Physicians' orders were clarified and followed for 4 of 15 sampled residents (1, 2, 3, and 8). *Nursing staff signed off medications prior to administering the medications for two of five medication pass observations. Findings include: 1. Review of resident 3's entire medical record revealed: *He had a physician's order for scheduled Seroquel (a drug used to treat schizophrenia or bipolar disorder) two times a day at 8:00 a.m. and 2:00 p.m.	F 281	<i>See next page</i>	

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F 281	<p>Continued From page 9</p> <p>*He had an order for an as needed (PRN) Seroquel to be given up to two additional times throughout the day.</p> <p>*A telephone order dated 8/9/13 stated to give the resident PRN Seroquel at noon to help with behaviors.</p> <p>*The telephone order would have made it scheduled at noon.</p> <p>*No clarification had been done on the telephone order.</p> <p>*Nursing staff had been using the PRN supply to provide the noon medication.</p> <p>*They had documented that noon dose on the PRN order on the medication administration record (MAR).</p> <p>*A sticky note had been attached to the first page of the August 2013 MAR that stated "per physician request...give 1 Seroquel 25 mg everyday at noon from PRN supply."</p> <p>Interview on 8/14/13 at 2:40 p.m. with the director of nursing (DON) revealed:</p> <p>*The telephone order should have been clarified prior to administering medication from the PRN supply.</p> <p>*A noon dosage would have been added to the medication administration record (MAR) as a scheduled medication.</p> <p>*A sticky note should not have been used on the MAR to relay the telephone order.</p> <p>2. Review of resident 3's 7/18/13 interdisciplinary note revealed he had a blood sugar of 262 at bedtime, and the insulin had been held. He had not eaten supper.</p> <p>Review of the July 2013 MAR regarding resident 3 revealed:</p> <p>*On 7/18/13 no recordings for blood sugar had</p>	F 281	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states with respect to:</p> <ol style="list-style-type: none"> 1. Resident #3's medication regimen has been revised. Resident #8's sliding scale insulin is given as ordered by physician and any changes in blood sugar and/or insulin needs the physician will be notified. Resident #1 daily weight has been reviewed by the physician and a new order is in place. Resident #2's juven order is in place and being given as ordered and signed on the MAR. 2. All nursing staff has been educated by 9-10-13 by the DNS on following physician orders and documenting why physician orders are not followed. Also included in the education was medication administration and explanation of mandatory 2 person checks on all insulin administrations. 3. All residents receive medications according to the physician order and it's documented as administered. 	

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F 281	<p>Continued From page 10 been documented at 12:00 noon or 5:00 p.m. *On 7/18/13 at bedtime he had a blood sugar of 262. *The physician's order had stated he was to have received 9 units of insulin if he had a blood sugar between 251 to 300. *He had not received any insulin at bedtime.</p> <p>Interview on 8/14/13 at 2:40 p.m. with the DON and the nurse consultant regarding resident 3 revealed the nurse should have given 9 units of insulin on 7/18/13 when his blood sugar was 262.</p> <p>Surveyor: 33265 Preceptor 29164 3. Review of resident 8's MARs and blood sugar log sheets from 6/1/13 through 8/12/13 revealed: *Her physician had ordered Humalog sliding scale insulin to be given four times a day based on four blood sugar results. *One nurse signed off on each sliding scale insulin dose calculation and administration.</p> <p>The June 2013 MAR documentation had the following six errors made in calculations of the sliding scale insulin dose: *Two 8:00 p.m. blood sugar readings had required 4 units of insulin and only 2 units had been administered. *Three 8:00 p.m. blood sugar readings had required 2 units of insulin and no units had been administered. * There was one 11:00 a.m. blood sugar reading where no insulin would have been required and 2 units had been administered with no initials of the person giving it.</p> <p>The July 2013 MAR documentation had the following sixteen errors made in missed blood</p>	F 281	<p>4. The DNS and/or her designee will audit residents' 1, 2, 3 and 8's medications for accuracy and compliance, and eight other residents with new medication orders or sliding scale insulin orders 3 times per week for one month and then four different residents 2 times per week for two months. <i>mm 9-27-13</i></p> <p>5. The data collected will be presented to the QA committee by the DNS. The data will be reviewed/discussed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies.</p> <p>6. The DNS is responsible for this area of compliance.</p>	10/03/13

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F 281	<p>Continued From page 11</p> <p>sugar values, copying of blood sugar values from monthly log to MAR, and in calculations of the sliding scale insulin dose required:</p> <p>*Six 8:00 p.m. blood sugar readings had required 2 units of insulin and no units had been administered.</p> <p>*Three blood sugar readings, one at 11:00 a.m. and two at 5:00 p.m. had not been documented.</p> <p>*Five errors in documentation occurred between 7/14/13 and 7/15/13. The exact same blood sugar values for the 6:00 a.m., 11:00 a.m. and 5:00 p.m. times were documented on the MAR for two dates, 7/14/13 and 7/15/13. The 11:00 a.m. and 5:00 p.m. values for 7/14/13 were then crossed off of the MAR. The blood sugar log had no values documented for those three times on 7/15/13. No documentation was found identifying the reason for the duplicated values on the MAR on 7/14/13 and 7/15/13, or the values crossed off of the MAR on 7/14/13, or the missing values from blood sugar log on 7/15/13.</p> <p>*One blood sugar value was documented as one value on the blood sugar log and as a different value on the MAR. No insulin was required for either documented value and no insulin was documented as given.</p> <p>*One blood sugar value was documented the same on both the blood sugar log and the MAR, then the original blood sugar value was crossed off and a lower value documented. The higher blood sugar value would have required 6 units of insulin. The lower blood sugar value required 2 units of insulin which was what was documented as being administered. No documentation was found which explained why the higher value which matched the blood sugar log was crossed off.</p> <p>The August 2013 MAR documentation had the following three errors made in calculations of the</p>	F 281			

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F 281	<p>Continued From page 12</p> <p>sliding scale insulin dose: One 5 p.m. blood sugar reading had required 6 units of insulin and only 4 units of insulin had been administered. One 8:00 p.m. blood sugar reading had required 2 units of insulin and no units of insulin were administered. One 5:00 p.m. blood sugar reading had required 2 units of insulin and 4 units of insulin had been administered.</p> <p>Interview on 8/13/13 at 5:00 p.m. with the DON regarding resident 8 revealed she agreed: *Errors had occurred in the administration, documentation, and calculation of the resident's sliding scale Humalog insulin. *Physician's orders had not been followed for the proper administration of the sliding scale Humalog insulin for the resident.</p> <p>Review of the provider's November 2002 Insulin Administration policy revealed "Two educated personnel" were to have checked each insulin dosage prior to administration of the insulin.</p> <p>Surveyor: 32572 4. Review of resident 1's weights and vitals summary sheet revealed a 5/22/13 physician's orders for daily weights had not been followed in: *June 2013, There had been ten days weights had not been documented. *July 2013, There had been twelve days weights had not been documented. *August 1 through 13, There had been three days weights had not been documented. There had not been any indication as to why the weights had not been done.</p> <p>5. Review of resident 2's medical record revealed</p>	F 281			

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F 281	<p>Continued From page 13</p> <p>a 7/24/13 physician's orders had not been followed for Juven (medication for wound healing) 1 package twice a day (BID) for 30 days. From August 1 through August 13 the MAR indicated the medication had not been given on six scheduled occasions.</p> <p>Interview on 8/14/13 at 1:45 p.m. with the DON confirmed she would have expected the weights to have been done, and the medications to have been given as ordered by the physician.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Edition, St. Louis, Mo., 2005, page 419, revealed: *The physician was responsible for directing medical treatment. Nurses were obligated to follow physicians' orders unless they believed the orders were in error or would harm clients. *The nurse's documentation could be the evidence of what actually was done for a client and could serve as proof that the nurse acted reasonably and safely. Documentation should have been thorough, accurate, and performed in a timely manner. To protect the nurse and the client, the nurse should have documented the care given and the details associated with it.</p> <p>6. Observation on 8/13/13 at the following times during medication administration revealed the MAR had been signed prior to medication administration: *From 10:35 a.m. through 11:17 a.m. LPN E had signed the MAR prior to administering the medications to residents. *From 8/13/13 at 11:50 a.m. through 12:00 noon, RN F had signed the MAR prior to administering the medications to the residents.</p>	F 281			

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F 281	Continued From page 14 Interview on 8/14/13 at 10:00 a.m. with the DON confirmed she would have expected the MAR to have been signed after the medications had been administered. Review of the provider's January 2005 Medication Administration General Guidelines policy revealed the medication should have been recorded at the time of the medication had been given. Review of a resolution issued by the South Dakota Board of Nursing at its September 12 and 13, 2006 meeting revealed: *Approved nursing education programs in the state had verified the standard for documentation of medication administration taught in nursing education was that documentation occurred following the administration of medication. *It was the position of the South Dakota Board of Nursing that the standard for safe administration of medication included the practice of documenting medication following administration to the patient.	F 281			
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to ensure interventions and activities on care plans were	F 282			

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F 282	<p>Continued From page 15 followed for two of three sampled residents (3 and 14) in the memory support unit (Birchwood Court). Findings include:</p> <p>1. Observation on 8/13/13 at 10:30 a.m. regarding resident 14 revealed she appeared agitated. She had been reaching out for staffs' hands as they went past her and scooting herself in her wheelchair in the hallway. When resident 3 came near her she would repeat "No, no, no, no." The closer resident 3 got to her the louder she became.</p> <p>Earlier in the morning medication technician G had informed this surveyor resident 14 did not like resident 3, and she got agitated just by his presence.</p> <p>Observation on 8/13/13 at 12:30 p.m. regarding resident 14 revealed she could not keep her eyes open at the lunch table. Staff repeatedly called her name to wake her up. She could not keep her eyes open as staff were feeding her. She could not lift up her arms when prompted.</p> <p>Review of resident 14's August 2013 medication administration record (MAR) revealed: *The as needed (PRN) sheet revealed the medication technician had given the resident Risperdal medication for "yelling/restless" at 10:40 a.m. on 8/13/13. *There were no attempted interventions documented on the MAR for the targeted behavior of yelling or cursing for the day shift on 8/13/13.</p> <p>Review of resident 14's 8/13/13 care plan revealed: *A focus area related to altered mood and</p>	F 282	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states with respect to:</p> <ol style="list-style-type: none"> 1. Resident #3 was seen by his physician for evaluation on 8-26-13 and medications have been adjusted and target behaviors/interventions were added to MAR/TAR. Resident #14 has been assessed and target behaviors/interventions have been added to MAR/TAR. 2. By September 11th, 2013 all nursing staff will be educated on resident Target Behaviors/Interventions. The RN Nurse Educator presented a synopsis from "CMS Hand in Hand" video on ways to intervene when residents are placed in difficult situations. 3. The DNS and/or her designee will audit residents' 3, 14 and all other residents on Birchwood court with target behaviors 3 times a week of two months, then 2 times a week for 1 month to verify target behaviors are monitored and interventions are being implemented. <i>ML 9-23-13</i> 	

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F 282	<p>Continued From page 16</p> <p>behaviors with the following interventions: -If agitated try redirecting her with a snack and/or hot chocolate. -She liked pets, so offer the unit cat for her to pet or visit about her dog. -If agitated and/or tearful visit with her and look at pictures of her family on her wall in her room. -She had a book about Elvis, and they were to offer her that book when she was agitated and/or tearful. *A focus area for activities with the following interventions: -Allow resident time to answer questions. -Family was important to her. -Listened to music, watched television. -Lost dog one year ago. -Loved Elvis. -Past interests included fishing, pool, cards, baseball, and crocheting. -Staff would seek her out for programs and one-to-one activities two times per week. *None of those interventions were listed on the MAR and had not been attempted prior to giving her the Risperdal medication on 8/13/13 at 10:40 a.m. to calm her down.</p> <p>2. Observation on 8/13/13 at 10:30 a.m. in Birchwood Court regarding resident 3 revealed: *Resident 3 came up behind resident 14 and started to push her wheelchair into the kitchen area where the floor had just been mopped. *Medication technician G and the nurse consultant watched resident 3 push resident 14 *The nurse consultant stated to be careful as to not bump her elbow. *No interventions were offered to resident 3 to occupy him at that time.</p> <p>Observation on 8/13/13 at 12:30 p.m. regarding</p>	F 282	<p>4. The data collected will be presented to the QA committee by the DNS. The data will be reviewed/discussed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies.</p> <p>5. The DNS is responsible for this area of compliance.</p>	10/03/13

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F 282	<p>Continued From page 17</p> <p>resident 3 revealed: *At lunch he had asked staff if he could help. *Staff stated no. *He was restless and moved from his spot to other residents' tables while waiting. *He had been upsetting residents 4 and 28. *Staff had not attempted any interventions to keep him from agitating the other residents. *Once lunch had been served he became less restless and left resident's 4 and 28 alone.</p> <p>Review of resident 3's 7/25/13 care plan revealed: *A focus area regarding negative behaviors with the following interventions: -Help him become familiar with the new environment and keep him busy with activities. -He liked to have tasks to accomplish such as wiping down tables. -Visit with him about life as a salesman, miner, cowboy, law man, and owning several businesses. -He used to fish in his spare time. -He always seemed to keep busy working on the family home. *A focus area for activities with the following interventions: -Liked to be outside. -Liked to watch all sports - Vikings and Twins. -Played poker and Pinochle. -Liked to fish and hunt. -Believed in God.</p> <p>Interview on 8/13/13 at 5:00 p.m. with medication technician G regarding residents 3 and 14 revealed: *She had not known what was care planned for either resident. *Interventions she had used were one-to-one and</p>	F 282		

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F 282	Continued From page 18 redirection for both residents. Interview on 8/14/13 at 10:30 a.m. with licensed practical nurse E revealed she had not known what interventions were care planned for residents 3 and 14. Interview on 8/14/13 at 2:40 p.m. with the director of nursing and the nurse consultant revealed individual care plan interventions should have been used for all residents. This surveyor requested a care plan implementation policy but instead received a Guidelines for Care Plan Completion policy that had not addressed how care plan interventions should have been implemented. No other policies regarding care plans had been received.	F 282		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329	<i>See next page</i>	

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F 329	<p>Continued From page 19</p> <p>drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to ensure medications were used for appropriate indications for 3 of 15 sampled residents (3, 5, and 14). Findings include:</p> <p>1. Observation on 8/13/13 at 10:30 a.m. regarding resident 14 revealed she had been agitated. She had been reaching out for staffs' hands as they went past her and scooting herself in her wheelchair in the hallway. When resident 3 came near her she would repeat "No, no, no, no." The closer resident 3 got to her the louder she became.</p> <p>Earlier in the morning medication technician G had informed this surveyor resident 14 did not like resident 3, and she got agitated just by his presence.</p> <p>Observation on 8/13/13 at 12:30 p.m. regarding resident 14 revealed she could not keep her eyes open at the lunch table. Staff repeatedly called her name to wake her up. She could not keep her eyes open as staff were feeding her. She could not lift up her arms when prompted.</p>	F 329	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states with respect to:</p> <ol style="list-style-type: none"> 1. Resident #14 and #3 do not receive antipsychotic PRN medication unless non-pharmological interventions have been attempted and failed and documented on MAR/TAR. 2. By September 11th, 2013 all nursing staff will be educated on where interventions are placed so that staff can readily review when situations arise. RN Nurse Educator presented synopsis from "CMS Hand in Hand" video on ways to intervene when residents are placed in difficult situations. 3. The DNS and/or her designee will audit all residents on the memory support unit for the use of non-medication interventions 3 times a week of two months, then 2 times a week for 1 month to verify target behaviors are monitored and interventions are being implemented prior to PRN medication being given. <p><i>WJL 9-24-13</i></p>	
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F 329	<p>Continued From page 20</p> <p>Review of resident 14's August 2013 medication administration record (MAR) revealed: *The as needed (PRN) sheet revealed the medication technician had given resident 14 Risperdal (medication used for schizophrenia and bipolar disorder) for "yelling/restless" at 10:40 a.m. on 8/13/13. *There were no attempted interventions documented on the MAR for the targeted behavior of "yelling or cursing" for the day shift on 8/13/13 before administering that medication.</p> <p>Review of resident 14's 7/17/13 through 8/13/13 PRN sheets revealed she had received Risperdal fourteen times for various reasons.</p> <p>Review of resident 14's July 2013 and August 2013 MARs revealed: *Nine out of the fourteen times staff had not documented any interventions attempted prior to administering the Risperdal medication.</p> <p>Review of resident 14's 8/13/13 care plan revealed: *A focus area related to altered mood and behaviors with the following interventions: -If agitated try redirecting her with a snack and/or hot chocolate. -She liked pets, so offer the unit cat for her to pet or visit about her dog. -If agitated and/or tearful visit with her and look at pictures of her family on her wall in her room. -She had a book about Elvis, so offer her that book when she is agitated and/or tearful. *A focus area for activities with the following interventions: -Allow resident time to answer questions. -Family was important to her. -Listened to music, watched television.</p>	F 329	<p>4. The data collected will be presented to the QA committee by the DNS. The data will be reviewed/discussed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies.</p> <p>5. The DNS is responsible for this area of compliance.</p>	10/03/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2013
NAME OF PROVIDER OR SUPPLIER ABERDEEN HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401		
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F 329	<p>Continued From page 21</p> <ul style="list-style-type: none"> -Lost dog one year ago. -Loved Elvis. -Past interest included fishing, pool, cards, baseball and crocheting. -Staff would seek her out for programs and one-to-one activities two times per week. <p>*None of those interventions were listed on the MAR and had not been attempted prior to giving her medication to calm her down.</p> <p>2. Review of resident 3's August 2013 PRN sheets revealed he had received Ativan (used for anxiety), Seroquel (used for agitation in Alzheimer's dementia) and trazodone (used for depression) a total of thirteen times for being "uncooperative", "restless", to "promote rest", and for "agitation."</p> <p>Review of resident 3's August 2013 MARs revealed there had been no target behaviors listed to monitor. Staff had not been using other interventions prior to using the above PRN medications.</p> <p>Review of resident 3's 7/25/13 care plan revealed: *A focus area regarding negative behaviors with the following interventions: -Help him become familiar with the new environment and keep him busy with activities. -He liked to have tasks to accomplish such as wiping down tables. -Visit with him about life as a salesman, miner, cowboy, law man, and owning several businesses. -He fished in his spare time. -He always seemed to keep busy working on the family home. *A focus area for activities with the following</p>	F 329			

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F 329	<p>Continued From page 22</p> <p>interventions: -Liked to be outside. -Liked to watch all sports - Vikings and Twins. -Played poker and Pinochle. -Liked to fish and hunt. -Believed in God.</p> <p>3. Interview on 8/13/13 at 5:00 p.m. with medication technician G regarding residents 3 and 14 revealed: *She had not known what was care planned for either resident. *Interventions she had used were one-to-one and redirection for both residents. *She had administered PRN medication when residents were agitated and after the nurse on duty had assessed the resident. *She had not documented when she had spoken with the nurse on duty to access resident's 3 and 14 prior to administering PRN medication.</p> <p>Interview on 8/14/13 at 10:30 a.m. with licensed practical nurse (LPN) E revealed she had: *Assessed residents before administering PRN medications. *Not always been aware of what interventions had been tried prior to her approving the use of PRN medications. *Not known what interventions were care planned for residents 3 and 14.</p> <p>Interview on 8/14/13 at 2:40 p.m. with the director of nursing (DON) and the nurse consultant revealed individual care plan interventions should have been used for all residents prior to administering PRN medications.</p> <p>Surveyor: 32333 4. Review of resident 5's entire medical record</p>	F 329		

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F 329	Continued From page 23 revealed the following: *1/14/13 a physician's order for Remeron (a medication used to increase appetite and an antidepressant) 15 milligrams. *2/8/13 a physician's order for a feeding tube placement. *7/15/13 a nurse's report to the physician stating "She was started on Remeron to stimulate her appetite. She is on tube feedings now. Does she need to continue on the Remeron?" *7/15/13 a physician's order to discontinue the Remeron. Interview on 7/14/13 at 3:10 p.m. with the DON regarding resident 5 revealed: *Remeron had been unnecessarily given to the resident while she was on a feeding tube. *They had not realized she was still on Remeron for appetite stimulation until July. *She was surprised the pharmacist had not caught the unnecessary medication.	F 329		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a	F 368	See next page	

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F 368	<p>Continued From page 24 resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29164 Based on interview, record review, and policy review, the provider failed to routinely offer evening snacks to all residents on oral diets. Findings include:</p> <p>1. Interview on 8/13/13 beginning at 11:20 a.m. with a group of ten random residents revealed when asked if they routinely received an evening snack, their answer was no they did not. They were not offered an evening snack but believed if they had asked for one, they would have received one.</p> <p>Surveyor: 32331 Interview on 8/13/13 at 11:30 a.m. and at 3:00 p.m. with the certified dietary manager revealed: *The dietary department set-up bedtime snacks in the three neighborhood refrigerators (Country Lane, Birchwood, and Arbor Avenue) in the evening between 6:00 p.m. and 7:00 p.m. *The nursing department was responsible for distributing the bedtime snacks to the residents.</p> <p>Interview on 8/13/13 at 3:30 p.m. with the director of nursing (DON) revealed: *The nursing department had not been documenting each resident that received snacks at night. *The dietary department had stocked the resident refrigerators with "a lot of food."</p>	F 368	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states with respect to:</p> <ol style="list-style-type: none"> 1. The facility has implemented a HS snack pass offering all residents a snack starting at 7pm. 2. Residents that are independent with eating will be monitored by dietary and residents requiring assistance will be monitored by licensed staff during the HS snack pass. Dietary and Nursing staff will be educated by September 25th, 2013 on the snack pass guidelines and documentation guidelines. 3. The Dietary Manager and/or her designee will audit the consumption records on those residents with a physicians' HS snack order or diet planned HS snack. <p><i>ME 8-27-13</i></p>	

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F 368	Continued From page 25 *Certified nursing assistants (CNA) were to ask residents if they wanted a snack at bedtime. *Residents with physicians' orders for specific snacks at bedtime were listed on the medication administration record (MAR) and were offered snacks. Record review of all residents on oral diets who had received a physician ordered bedtime snack on the MAR were a total of two residents, 25 and 29. Interview on 8/14/13 at 3:30 p.m. with the registered dietitian confirmed all residents were to have been offered bed time snacks. Review of the provider's May 2011 Between Meal Nourishment and Bedtime Snacks policy revealed snacks would be offered to all residents in the evening at bedtime.	F 368	4. The data collected will be presented to the QA committee by the Dietary Manager. The data will be reviewed/discussed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies. 5. The Dietary Manager is responsible for this area of compliance.	10/03/13
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy	F 371	<i>See next page</i>	

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F 371	<p>Continued From page 26</p> <p>review, the provider failed to ensure sanitary conditions were maintained:</p> <p>*For storing meats in the refrigerator in the walk-in cooler in the kitchen.</p> <p>*For storing Resource 2.0 (high calorie and protein medication pass supplement) on two of five medication carts (Country Lane) for extended periods of time without cooling.</p> <p>Findings include:</p> <p>1. Observation on 8/13/13 at 7:31 a.m. in the walk-in refrigerator on a plastic tray in the kitchen revealed:</p> <p>*Loosely wrapped, undated roast beef slices in a plastic bag covered in foil.</p> <p>*Loosely wrapped, undated pork patties in thick white, wax-type paper in a white plastic bag.</p> <p>*A wrapped ten-pound ham.</p> <p>*The tray had approximately one-eighth inch of liquids on the bottom that the above items were setting in.</p> <p>Interview on 8/13/13 at 11:40 a.m. with the certified dietary manager confirmed the storage and thawing of the different types of meat items needed to be separated to prevent cross-contamination.</p> <p>Interview on 8/14/13 at 7:00 p.m. with the registered dietitian confirmed the storage and thawing of the different types of meat items needed to be separated to prevent cross-contamination.</p> <p>Review of the provider's undated Food Storage-Perishable policy revealed sanitary procedures would be maintained in perishable food storage to keep food safe, wholesome, appetizing, and to prevent contamination.</p>	F 371	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states with respect to:</p> <ol style="list-style-type: none"> 1. The meat observed on the tray was discarded. 2. A refrigerator safety poster was posted in kitchen on 9-3-13 for all dietary staff to review to prevent cross contamination. 3. Supplement use and storage guideline was implemented. Supplements will be dated when opened and stored in a cold storage container on the med cart while in use. All supplements will be discarded after med pass. All nursing staff was educated on 8-15-13 regarding the supplement use guidelines. 4. The Dietary Manager and DNS and/or her designee will audit the proper storage of supplements on the med cart, and the proper discarding of the supplement after all med passes for three days per week for one month and then two days a week for two months. <p><i>max 9-25-13</i></p>	

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F 371	Continued From page 27 According to the FDA (Food and Drug Administration) Food Code 3-302.11 food shall be protected from cross-contamination by separating raw animal foods during storage, preparation, holding, and display for raw ready-to-eat food, including fruits and vegetables, as well as cooked ready-to-eat foods. Surveyor: 32572 2. Random observations from 8/13/13 through 8/14/13 revealed Resource 2.0 cartons had been sitting on top of two medication carts. *Those containers had been sitting on top of medication carts 1 and 2 on Country Lane for 11.5 hours. The cartons had not been refrigerated or chilled during that time. *The cartons had not been marked as to when they had been opened. *The Resource containers had instructions to refrigerate after opening. Interview on 8/14/13 at 2:00 p.m. with the director of nursing confirmed she would have expected the Resource 2.0 cartons to have been on ice when not in the refrigerator and dated when opened.	F 371	5. The data collected will be presented to the QA committee by the Dietary Manager. The data will be reviewed/discussed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies. 6. The Dietary Manager is responsible for this area of compliance.	10/03/13
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	<i>See next page</i>	

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F 431	Continued From page 28 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, and policy review, the provider failed to ensure: *Security of the key to the narcotics (controlled medications) box for one (Birchwood) of five medication carts. *Proper storage of medications for one (cart one on Country Lane) of five medication carts. *Dating of two insulin pens and one insulin multi-use vial in one (cart one on Country Lane) of five medication carts.	F 431	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. Only nurses have access to the narcotic boxes on the medication carts. All medications/insulin are dated when opened. Medications are properly stored i.e. bug spray and sunscreen. All expired medications are properly disposed of. All medications are properly stored and chemicals are locked up. 2. The Nurses' will be educated by September 11 th , 2013 to review the procedure regarding documenting the date opened on all newly opened medication/insulin, and the disposal of all expired medications. Proper medication storage was also reviewed with the nurses.	

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F 431	<p>Continued From page 29</p> <p>*Disposal of expired medications had been completed for one (cart two on Country Lane) of five medication carts and one (Country Lane) of two medication rooms.</p> <p>*Proper storage of Cutter bug spray and Coppertone sunscreen in one (Country Lane) of two medication rooms.</p> <p>*Proper storage of eye drops, injectable medications, and topical medications on one of five medication carts.</p> <p>*Proper storage of medicated shampoo and cleanser in one (C-wing) of three shower rooms.</p> <p>Findings include:</p> <p>1. Observation on 8/14/13 at 10:00 a.m. of unlicensed assistive personnel (UAP) A revealed she had access to the key to the narcotic drawer of the medication cart in Birchwood Court. She was able to open the narcotic drawer and show this surveyor the narcotics within the drawer.</p> <p>Interview on 8/14/13 at 10:00 a.m. with UAP A revealed she had been instructed not to obtain medications from that drawer.</p> <p>Interview on 8/14/13 at 2:00 p.m. with the director of nursing (DON) confirmed she would not have expected the UAP to have had a key to the narcotic drawer.</p> <p>Review of the provider's January 2005 Medication Administration General Guidelines policy revealed there was no indication security for the narcotic key was needed.</p> <p>2. Observation on 8/13/13 at 8:00 a.m. revealed eye drops and a nitroglycerin patch had been left unsecured on the top of one of two medication carts in Country Lane.</p>	F 431	<p>3. The DNS and/or her designee will audit the medication room/medication carts 2 times a week for two months and then 1 time a week for 1 month for proper storage, expired medications and medications that are not dated but opened. We will also audit the proper storage and handling of the key to the narcotic box for compliance with the facility's security policy and procedure on all shifts for three days per week for two months, and then two days a week for one month.</p> <p>4. The data collected will be presented to the QA committee by the DNS. The data will be reviewed/discussed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies.</p> <p>5. The DNS is responsible for this area of compliance.</p> <p><i>9-23-13 NJK</i></p>	10/03/2013	

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F 431	<p>Continued From page 30</p> <p>Interview on 8/14/13 at 2:00 p.m. with the DON confirmed she would have expected the medications to have been locked within the medication cart when staff were not near it.</p> <p>Review of the provider's January 2005 Medication Administration General Guidelines policy revealed "No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications."</p> <p>3. Observation on 8/14/13 at 10:00 a.m. of medication cart two on Country Lane revealed two insulin pens and one insulin multi-use vial without a date indicating when they had been opened.</p> <p>Interview on 8/14/13 at 2:00 p.m. with the DON confirmed she would have expected the insulin to have been dated.</p> <p>Review of the provider's revised November 2002 Insulin Administration policy did not indicate the need to date insulin when opened.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6 th Ed., St. Louis, MO., 2005, p. 881, revealed the insulin "Potency may increase or decrease when outdated" indicating dating when opening was necessary.</p> <p>4. Observation on 8/14/13 at 10:00 a.m. of the following medication carts and medication room revealed expired medications. *Cart 2 on Country Lane had a bottle of hydrogen peroxide that had expired May 2013. *The medication room on Country Lane had:</p>	F 431		
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F 431	<p>Continued From page 31</p> <p>-A bottle of hydrogen peroxide expired March 2013.</p> <p>-A bottle of liquid acetaminophen expired April 2013.</p> <p>-Four bottles of isopropyl alcohol expired March 2013.</p> <p>-A bottle of Coppertone sunscreen lotion expired June 2013.</p> <p>Interview on 8/14/13 at 2:00 p.m. with the DON confirmed she would have expected expired medications to have been properly disposed of.</p> <p>Review of the provider's January 2005 Medication Administration General Guidelines policy revealed it did not indicate how to have disposed of expired medications.</p> <p>5. Observation on 8/14/13 at 10:00 a.m. of Country Lane medication room revealed a bottle of Cutter bug spray and a bottle of Coppertone sunscreen had been stored in the cupboard with liquid medications.</p> <p>Interview on 8/14/13 at 2:00 p.m. with the DON confirmed she would have expected the bug spray and sunscreen to have been stored away from medications.</p> <p>6. Observation on 8/14/13 at 10:00 a.m. of the Birchwood Court medication cart revealed a compartment within the top drawer had suppositories, eye drops, and glucagon all stored within that compartment.</p> <p>Interview on 8/14/13 at 2:00 p.m. with the DON confirmed she would have expected the items to have been stored separately within the top drawer.</p>	F 431			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/14/2013
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NAME OF PROVIDER OR SUPPLIER ABERDEEN HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 431	<p>Continued From page 32</p> <p>Review of the provider's January 2005 Medication Administration General Guidelines policy revealed it did not indicate proper storage of medications within the medication carts.</p> <p>Surveyor: 32333 7. Observation on 8/14/13 at 10:10 a.m. of the C wing shower room revealed: *An unlocked storage unit had several plastic storage bins. *One of those plastic storage bins had contained: -Hibiclens 4.0% prescription cleanser for resident 30. -Clobex 0.05% prescription shampoo for resident 31.</p> <p>Interview on 8/14/13 at 3:10 p.m. with the DON confirmed that medicated cleanser and shampoo should not have been stored in the shower room in an unlocked cabinet.</p>	F 431		
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective</p>	F 441	<p><i>See next page</i></p>	

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F 441	Continued From page 33 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of two certified nursing assistants (CNA) (H) knew the proper procedure to disinfect the whirlpool tub and shower in one (C-wing bathing room) of three bathing rooms. *Resident items were stored in a sanitary manner in one (C-wing bathing room) of three bathing rooms. *Shelves used to store clean towels were free from chipped paint and raw wood surfaces in three of three bathing rooms. *Proper infection prevention and control had been	F 441	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states with respect to: 1. The facilities Infection Control Surveillance Policy and Procedure has been reviewed and updated to meet current regulations. 2. All employees have been educated by September 11 th , 2013 in regards to infection prevention, monitoring, the infection control manual, proper hand washing and disinfecting the tub/shower rooms. Education was also completed on disinfecting the glucose monitors and proper maintenance. 3. The facility will track infections and surveillance infections according to the facility policy and procedure.		

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F 441	<p>Continued From page 34</p> <p>maintained during four of four residents (2,3,and 4) observed dressing changes by registered nurse (RN) (F) and lisened practical nurse (LPN) (E).</p> <p>*The blood sugar monitoring machine had been disinfected properly between residents 3 and 25 by LPN E and unlicensed assistive personnel (UAP) (G).</p> <p>*UAP A sanitized her hands between administration of medications during noon medication pass observation to residents (9, 21, and 23).</p> <p>*An effective infection prevention and control program had been maintained.</p> <p>Findings include:</p> <p>1. Interview on 8/13/13 at 2:55 p.m. with CNA H revealed she had worked at the facility for approximately three months. She stated all CNAs were responsible for showering and bathing residents. When asked about cleaning of the shower and whirlpool tub after giving resident baths and showers she stated she:</p> <p>*Sprayed the shower with a quat disinfectant. *Rinsed the quat disinfectant immediately after applying it. *Did not know how to clean the whirlpool tub. *Had never used the whirlpool tub. *Had received no training on cleaning the whirlpool tub.</p> <p>Review of the quat disinfectant's label revealed "Use a ten minute contact time for disinfection."</p> <p>2. Observation on 8/14/13 at 10:10 a.m. in the C wing shower room revealed:</p> <p>*An unlocked storage unit that had several plastic storage bins. *One of those plastic storage bins contained</p>	F 441	<p>4. The DNS and/or her designee will monitor the infection surveillance log daily for two months. Then weekly for one month. Then further data will be collected for infection tracking and reporting as needed. There will also be an audit completed three times per week for two months for the proper disinfecting of the whirlpool tub and the proper storage of resident use items. Another audit will be completed 2 times per week for one month and then 1 time per week for one month every C.N.A, nursing and UAP staff member for proper hand washing, hand hygiene, and glove use during medication pass and dressing changes.</p> <p>5. The data collected will be presented to the QA committee by the DNS. The data will be reviewed/discussed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies.</p> <p>6. The DNS is responsible for this area of compliance.</p> <p><i>Done 9.23.14</i></p>	10/03/2013

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F 441	<p>Continued From page 35</p> <p>several resident use items and other random items commingled including:</p> <ul style="list-style-type: none"> -A prescription cleanser for resident 30. -A prescription shampoo for resident 31. -Unlabeled perineal wash, a razor, paper tape, a key, and a hair pick. <p>3. Observation from 8/13/13 through 8/14/13 of all three residents' bathing rooms revealed the shelves used for storage of the clean towels had chipped paint and raw wood surfaces. Those areas created an uncleanable surface.</p> <p>4. Review of the provider's April, May, and June 2013 facility monthly infection control reports and infection rate forms revealed:</p> <ul style="list-style-type: none"> *April 2013 had seventeen infections documented. -Fourteen of the seventeen infections had no type of infectious organism documented. -Nine of the seventeen had no documentation of whether or not the infection had been present upon the resident's admission. -None of the seventeen had any documentation of whether or not precautions had been used to prevent the spread of infection. <p>*The May 2013 form had twenty-six infections documented.</p> <ul style="list-style-type: none"> -Twenty-four of the those did not any documentation any cultures had been completed. -Only one had the infectious organism identified. -Twenty-one of those did not indicate if the infections had been present upon the resident's admission. -There was no documentation any precautions had been used during care for those residents to prevent the spread of infection. 	F 441		
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F 441	<p>Continued From page 36</p> <p>*June 2013 had been the last form completed. It contained documentation of six infections. That form had not contained: -Room numbers of the residents that had infections. -If any of the infections had been present on the resident's admission. -If any precautions had been used to prevent the spread of infection.</p> <p>5. Interview on 8/14/13 at 3:10 p.m. with the director of nursing revealed she: *Did not know where the infection control policies and procedures were maintained. *Would have to review the policies and procedures on monitoring infections and implementing procedures. *Had not been tracking and trending infections effectively. *Had not been monitoring the effectiveness of training provided. *Did not know the proper procedure for the disinfection of the whirlpool tubs and showers. *Did not discuss infection prevention and control at the quality assurance meetings. *Would have expected CNA H to know the proper procedure for cleaning and disinfecting the whirlpool tub and showers. *Agreed resident use items, cleansing products, and other random items had been stored in an unsanitary manner.</p> <p>Surveyor: 32572</p> <p>6. Observation of registered nurse (RN) F and licensed practical nurse (LPN) E performing dressing changes on residents 2, 3, 4, and 19 revealed: * Hand washing had not been performed 10 to 15</p>	F 441			

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F 441	<p>Continued From page 37</p> <p>seconds:</p> <p>-On 8/13/13 at 2:20 p.m. through 2:40 p.m. RN F had washed her hands for 3 to 7 seconds before and after glove use while performing a dressing change on residents 2 and 19.</p> <p>-On 8/13/13 from 2:45 p.m. through 3:20 p.m. LPN E had washed her hands for 3 to 5 seconds before and after glove use while performing a dressing change on residents 3 and 4.</p> <p>*A barrier had not been established prior to opening the clean supplies at the following times:</p> <p>-On 8/13/13 from 2:20 p.m. through 2:40 p.m. RN F placed clean dressing supplies directly on resident 2's bed prior to the dressing change.</p> <p>-On 8/13/13 from 2:45 p.m. through 3:20 p.m. LPN E placed clean resident dressing supplies on the residents 3 and 4's bed.</p> <p>*On 8/13/13 from 2:20 p.m. through 2:40 p.m. RN F had taken a container from room to room.</p> <p>-That container had numerous resident wound care supplies in it.</p> <p>-The container had been set on the residents' sink area as on residents' wheelchair seats while wound care had been performed.</p> <p>Interview on 8/14/13 at 10:00 a.m. with the DON confirmed she would have expected:</p> <p>*Hand washing to have been performed for 10 to 15 seconds as the policy stated.</p> <p>*A barrier to have been placed if clean dressings were going to be placed in resident care areas.</p> <p>*Only the supplies needed for the specific dressing change should have been taken into residents' rooms.</p> <p>Review of the provider's November 2002 Dressing - Sterile policy did not indicate a barrier was needed while performing a dressing change.</p>	F 441		
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F 441	<p>Continued From page 38</p> <p>Review of the provider's undated Procedure for Hand washing policy revealed hand washing should have been performed for 10 to 15 seconds.</p> <p>7. Observation of LPN E and unlicensed assistive personnel (UAP) G as they performed blood glucose checks on three observations revealed: *On 8/13/13 at 12:03 p.m. LPN E completed a blood sugar check on resident 25 and had placed the meter into the carrying container without cleaning it. *On 8/13/13 at 5:04 p.m. UAP G completed a blood sugar check on resident 25 and had placed the meter into the container without cleaning it. *On 8/13/13 at 5:20 p.m. UAP G completed a blood sugar check on resident 3 and had placed the meter into the container without cleaning it.</p> <p>Interview on 8/14/13 at 10:00 a.m. with the DON confirmed she would have expected the glucometer to have been cleaned prior to placing it back into the carrying case.</p> <p>Review of the provider's undated Blood Glucose Meter Cleaning and Disinfecting Policy and Procedure revealed options for cleaning were: *A 1 to 10 solution of household bleach. *PDI Sani-Cloth Super (a disinfectant wipe). *HB Germicidal disposal wipes. All of those were to have been wiped on and left to air dry before use on the next resident.</p> <p>Surveyor: 29164 7. Observation on 8/13/13 at 12:00 noon of UAP A during medication administration revealed she had not sanitized her hands between residents 9, 21, and 23 when she had administered their</p>	F 441		
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F 441	Continued From page 39 medications. Interview on 8/14/13 at 9:30 a.m. with the DON revealed she expected staff administering medications to sanitize their hands between residents. Review of the provider's Guidelines for Handwashing policy dated 8/14/13 stated to wash hands before and after each resident contact.	F 441			

ORIGINAL

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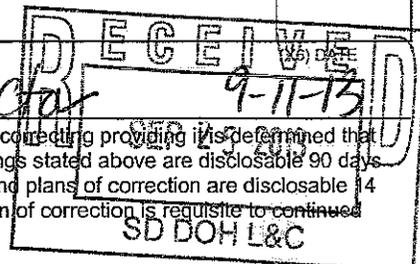
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/14/2013
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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted from 8/13/13 through 8/14/13. Aberdeen Health and Rehab was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 8/14/13 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column (X5) for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K018, K029, and K038 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 018 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	See next page	

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

TITLE

Megan Kleinsasser

Exec Director



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

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain the smoke tight rating of corridor wall assemblies for 2 of 11 smoke compartments (east tub room in the C wing and the laundry room in the service wing). Findings include: 1. Observation on 8/13/13 at 3:45 p.m. revealed the corridor doors to the east tub room in the C wing would not close into the frame. The door would stick and the self-closing device installed on the door was not able to pull the door completely shut. That had the potential to jeopardize that smoke compartment. 2. Observation on 8/14/13 at 9:30 a.m. revealed the corridor doors to the laundry room in the service wing would not close into the frame. The door would stick and the self-closing device installed on the door was not able to pull the door completely shut. That had the potential to jeopardize that smoke compartment. Interview with the maintenance supervisor at the time of observation confirmed those findings and indicated that he had checked those doors as part of his preventative maintenance last month.	K 018	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. The door in the C wing has been fixed as of 8-14-13 and is now properly closing in frame. The door in the corridor to the laundry room is now properly closing in frame as of 8-14-13. 2. The Maintenance Supervisor and/or his designee will audit every fire door weekly by visual inspection for 3 months to ensure they are properly latching. 3. These doors have been added to the preventative maintenance checklist. The Maintenance Supervisor is responsible for this area of compliance. <i>MIL 9-23-13</i>	10/03/2013

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K 029 K 029 SS=D	Continued From page 2 NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to maintain proper separation of hazardous areas in one of one location (the corridor door to the soiled linen room in the service wing) as it would not close and latch into the frame. Findings include: 1. Observation and testing at 9:30 a.m. on 8/14/13 revealed the door to the soiled linen room would stick. The self-closing device installed on the door was not able to pull the door completely shut. That malfunction jeopardized the required fire rating of that room. Interview with the maintenance supervisor at the time of observation confirmed those findings and indicated that that door had been functioning properly last he had checked and that a loose screw near the latch was causing the malfunction.	K 029 K 029	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. The door to the solid linen room is now functioning properly as of 8-14-13. 2. The Maintenance Supervisor and/or his designee will audit every fire door weekly by visual inspection for 3 months to ensure they are properly latching. 3. This door has been added to the preventative maintenance checklist. The Maintenance Supervisor is responsible for this area of compliance.	10/03/2013
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

*NW
9-27-13*

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/14/2013
NAME OF PROVIDER OR SUPPLIER ABERDEEN HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038 SS=D	Continued From page 3 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure exits were readily accessible at all times. Two of eleven exits (front entrance and south exit from secure unit) from the facility were not readily accessible at all times. The front entrance was equipped with delayed egress lock for residents provided with wander management control but appropriate signage was not available indicating the egress procedure. The south entrance from the secure unit was equipped with a magnetic lock that did not unlock when fire alarm was activated. Findings include: 1. Observation and interview at 3:30 p.m. on 8/13/13 revealed the main entrance doors were equipped with a wander management system. That system was capable of providing delayed egress to those residents provided with a wander management bracelet. There was no visible sign stating "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". Interview with the maintenance supervisor at the time of observation revealed he would have proper signage posted as soon as possible. 2. Observation, testing, and interview at 11:00 a.m. on 8/14/13 revealed the south exit door from the secure wing was equipped with a magnetic	K 038	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. The signage has been posted on all doors with delayed egress. The secured unit door has been rewired to open in the event of the fire panel being activated as of 8-26-13. 2. The Maintenance Supervisor/and or his designee will designate someone during each fire drill to be responsible to check these doors to ensure they are unlocking upon activation of fire alarm. 3. The Maintenance Supervisor is responsible for this area of compliance. <i>MW</i> <i>8-23-13</i>	10/03/2013

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K 038	Continued From page 4 locking device. The device shall be installed to release the magnetic lock upon initiation of the fire alarm. When the fire drill was being conducted for this survey testing of that door revealed it was still unable to be opened. Interview with the maintenance supervisor after the fire drill revealed he was unaware that door was not unlocking and indicated he would have it rewired as soon as possible.	K 038		
K 052 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to install the south exit manual pull station in the secure wing at the proper height. Findings include:</p> <p>1. Observation at 4:15 p.m. on 8/13/13 revealed the manual pull station at the east exit of the C wing was mounted so the operating part of the station was 60 inches above the finished floor. Interview with the maintenance supervisor at the</p>	K 052	<i>See next page</i>	

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K 052	Continued From page 5 time of the observation revealed the remainder of the fire alarm pull stations were also at that same height. The height for mounting a manual pull station is to have the operating part of the pull station between 42 to 54 inches above the finished floor. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 052		F	

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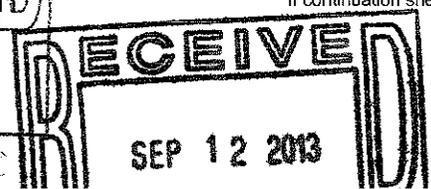
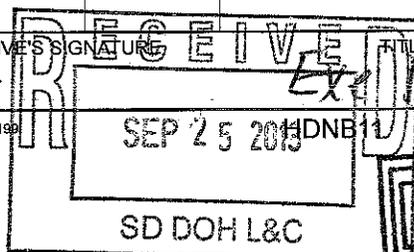
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S 000	Initial Comments Surveyor: 12218 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/13/13 through 8/14/13. Aberdeen Health and Rehab was found not in compliance with the following requirement: S253	S 000		
S 253	44:04:04:11.01 SECURED UNITS Each facility with secured units must comply with the following provisions: (1) A physician's orders for confinement that includes medical symptoms that warrant seclusion or placement must be documented in the...resident's chart and must be reviewed periodically by the physician; (2) Therapeutic programming must be provided and must be documented in the overall plan of care; (3) Confinement may not be used as a punishment or for the convenience of the staff; (4) Confinement and its necessity must be based on a comprehensive assessment of the...resident's physical and cognitive and psychosocial needs, and the risks and benefits of this confinement must be communicated to the...resident's family; (5) Locked doors must conform to Sections 18.2.2.2.4 and 19.2.2.2.4 of NFPA 101 Life Safety Code, 2000 edition; and (6) Staff assigned to the secured unit must have specific training regarding the unique needs of...residents in that unit. At least one caregiver must be on duty on the secured nursing unit at all times.	S 253	<i>See next page</i>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Megan Kleinsasser TITLE: Exec Director (X6) DATE: 9-11-13



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S 253	<p>Continued From Page 1</p> <p>This Rule is not met as evidenced by: Surveyor: 32335 Based on observation, record review, policy review, and interview, the provider failed to ensure there was a therapeutic activity program for one of one memory support unit (Birchwood Court) for three of three sampled residents (3, 4, and 14). Findings include:</p> <p>1. Random observations from 8/13/13 through 8/14/13 in Birchwood Court revealed: *There had been eleven residents who resided in Birchwood Court. *The television had generally been on in the living area. *After meals residents sat in the recliners in the living area. *On 8/13/13 an activity of bowling had occurred with four to five of the residents. *That activity had been led by certified nursing assistant (CNA) I who did not regularly work in Birchwood Court. *There had been no group activities in the afternoon. *CNA C played scrabble with one resident. *Resident 3 had been given play tools to occupy his time one morning. *Resident 4 had been looking at magazines one afternoon. *Resident 14 had no activities during the observation time.</p> <p>2. Review of resident 3's activity records revealed: *In July 2013 he had no activities documented for eight out of sixteen days. *The activities listed that he had participated in were one-to-one visits, games, and music programs/videos. *In August 2013 he had four out of twelve days with no activities.</p>	S 253	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states with respect to:</p> <ol style="list-style-type: none"> 1. A recreation wellness assessment was completed for residents #3, #4, and #14. Their care plans have been updated to reflect the wellness assessment. 2. All residents in the secured unit have been assessed for recreation wellness needs. 3. Daily activity programming has been implemented for the secured unit. All activity staff will be educated by September 20th, 2013, regarding attendance tracking and documentation.

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S 253	<p>Continued From Page 2</p> <p>*The only activity listed that he had participated in was one-to-one visits.</p> <p>Review of resident 3's 7/25/13 care plan revealed: *A focus area regarding negative behaviors with the following interventions: -Help him become familiar with the new environment and keep him busy with activities. -He liked to have tasks to accomplish such as wiping down tables. -Visit with him about life as a salesman, miner, cowboy, law man, and having owned several businesses. -He used to fish in his spare time. -He always seemed to keep busy working on the family home. *A focus area for activities with the following interventions: -Liked to be outside. -Liked to watch all sports - Vikings and Twins. -Played poker and Pinochle. -Liked to fish and hunt. -Believed in God.</p> <p>Interview on 8/13/13 at 3:30 p.m. with medical technician G revealed they had locked the door to the outside courtyard due to resident 3. She had stated he liked to be outside but that it was a safety concern. He had not always stayed on the sidewalk with his wheelchair.</p> <p>3. Review of resident 4's activity records from 6/1/13 through 7/31/13 revealed: *There had been seven days when she had participated in activities other than one-to-one visits and self leisure pursuits. *Those activities were reading/magazines documented once, church documented seven times, music programs documented four times, television viewing documented once, puzzles</p>	S 253	<p>4. The Community Life Coordinator and/or her designee will monitor attendance and maintain activity participation records on all residents in Birchwood Court 2 times a week for 2 months and then 1 time a week for 1 month.</p> <p>5. The data collected will be presented to the QA committee by the Community Life Coordinator. The data will be reviewed/discussed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies.</p> <p>6. The Community Life Coordinator is responsible for this area of compliance.</p> <p><i>MLL 9-23-13</i></p>	10/03/2013

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S 253	<p>Continued From Page 3</p> <p>documented once, movies documented six times, nails documented once, and exercise documented three times.</p> <p>Review of resident 4's 6/17/13 care plan revealed the following interventions: *Faith was important to her. *Family was important to her. *Liked to be around people. *Liked to help others. *Liked to nap in the afternoons. *Past interests were baking, cooking, and sewing.</p> <p>4. Review of resident 14's June 2013 activity log revealed: *Birchwood staff had documented she had been in the hospital from 6/1/13 through 6/7/13. *The activities staff had documented she had participated in activities during that time. *Birchwood staff had documented seven days out of the month where she had activities including reading, nails, movie, music, and outdoors.</p> <p>Review of resident 14's July 2013 activity log revealed staff had documented seventeen days out of the month where she had participated in activities other than one-to-one activities and self leisure pursuits.</p> <p>Review of resident 14's 8/13/13 care plan revealed: *A focus area related to altered mood and behaviors with the following interventions: -If agitated try redirecting her with a snack and/or hot chocolate. -She liked pets so offer the unit cat for her to pet or visit about her dog. -If agitated and/or tearful visit with her and look at pictures of her family on her wall in her room.</p>	S 253		
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S 253	<p>Continued From Page 4</p> <p>-She had a book about Elvis, and they were to offer her that book when she was agitated and/or tearful.</p> <p>*A focus area for activities with the following interventions:</p> <ul style="list-style-type: none"> -Allow resident time to answer questions. -Family was important to her. -Listened to music, watched television. -Lost dog one year ago. -Loved Elvis. -Past interest included fishing, pool, cards, baseball, and crocheting. -Staff would seek out for programs and offer one-to-one activities two times per week. <p>5. Interview on 8/14/13 at 7:30 a.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> *There were no activities being done in Birchwood Court. *She felt if more activities were being done less behaviors would occur. *She had CNA I lead activities in the unit on occasion. <p>Interview on 8/13/13 at 8:00 a.m. with community life assistant J revealed she had not been down on Birchwood Court to lead activities for awhile since CNA I had been leading them.</p> <p>Interview on 8/14/13 at 2:50 p.m. with the community life coordinator revealed:</p> <ul style="list-style-type: none"> *The activities calendar for Birchwood Court had been the same as the nursing home activities calendar with the addition of a special programs calendar. *The special programs calendar for August 2013 had twelve events listed for the month. *Seven of the twelve events had been "off the unit." *She stated they tried to take residents from Birchwood Court off the unit when they could. 	S 253		

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S 253	<p>Continued From Page 5</p> <p>*She stated community life assistant J led activities on the unit. *CNA I had not been a part of the activities department. *She had not been aware community life assistant J had not been on the unit since CNA I was leading activities.</p> <p>Review of the provider's March 2010 Birchwood Court Policy and Procedures revealed residents would be admitted only if the individual was able to participate in consistent, daily programming in a therapeutic environment. It did not define what the daily programming would include.</p>	S 253		