

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PIERRE			STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET PIERRE, SD 57501	
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F 000	INITIAL COMMENTS	F 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.	
F 176 SS=F	<p>Surveyor: 29162 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/7/13 through 1/10/13. Golden LivingCenter - Pierre was found not in compliance with the following requirements: F176, F241, F253, F280, F281, F309, F314, F431, F441, F490, F508, F514, and F520.</p> <p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Precepted by: 26632 Based on observation, record review, interview, and policy review, the provider failed to care plan for 2 of 22 residents (10 and 18) for the self-administration of medications. Findings include:</p> <p>1. Observation on 01/8/13 from 8:00 a.m. to 9:00 a.m. at a meal service of registered nurses (RN) D and E while they passed medications revealed: *RN D had set resident 10's medications on the table in front of her and walked away. *RN E had set resident 18's medications on the table in front of her and walked away.</p> <p>Review of a list provided by the director of nursing</p>	F 176	<p>F176</p> <p>1. All residents who can self administer medications are at risk. Resident 10 and 18 have had their plan of care updated.</p> <p>2. The Director of Nursing Services (DNS) will in-service nurses and medication aides no later than February 1, 2013 on ensuring the plan of care includes self administration of medications before nurses may allow resident to self</p>	2/7/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jalli Raske TITLE: Executive Director (X6) DATE: 3/1/13 *revised*

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

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F 176	<p>Continued From page 1</p> <p>upon request revealed 22 residents had been approved to self-administer medications. Residents 10 and 18 had been included on that list.</p> <p>Review of resident 10's last updated 11/13/12 care plan revealed: *Self-administration of medications had not been care planned. *A care conference form signed 1/8/13 by the interdisciplinary team stating resident 10 was able to safely self-administer medication was attached to the back of the care plan. *That form was not individualized. *That form had not included a focus area, goals, or interventions.</p> <p>Review of resident 18's last updated 11/27/12 care plan revealed: *Self-administration of medications had not been care planned. *A care conference form signed by the interdisciplinary team on 12/18/12 stating resident 18 was able to safely self-administer medication was attached to the back of the care plan. *That form was not individualized. *That form had not included a focus area, goals, or interventions.</p> <p>Interview with the DON on 1/9/13 at 3:15 p.m. confirmed self-administration of medication orders for residents 10 and 18 had not been care planned.</p> <p>Review of the provider's self-administration of medications by patients policy revised 10/1/03 stated "If the patient desires to self-administer medications, an assessment is conducted by the</p>	F 176	<p>administer any medications. The policy and procedure will be reviewed, including assessment of resident's capability and appropriate practices and assessment and following appropriate medication administration practices.</p> <p>3. All residents who self administer medication have had their assessments reviewed to ensure they are capable to self administer medications and their care plans have been reviewed to ensure the self administering of medications is included. The DNS or designee will audit 4 random residents a week for four weeks and then monthly for 3 months to ensure self administration of medications is included on the plan of care. Results of audits will be reported by the DNS and discussed at monthly Quality Assurance and Assessment (QA&A) meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>4. February 7, 2013</p>		

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F 176	Continued From page 2 interdisciplinary team of the patient's cognitive, physical, and visual ability to carry out this responsibility. Self-administration of medications is also to be included as part of the patient's care plan."	F 176			
F 241 SS=C	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Surveyor: 32333 Preceptor: 26632 Based on observation, interview, and document review, the provider failed to ensure dignity at three of three meal services for all residents who required feeding assistance. Findings include: 1. Observation on 1/7/13 from 5:45 p.m. to 6:30 p.m. of the meal service revealed: *Residents who required feeding assistance were seated in the dining room at 5:45 p.m. at specified tables. *Those residents were served their meals at 6:25 p.m. *Independent residents were served their meals before residents who required feeding assistance, Observation on 1/8/13 from 12:05 p.m. to 12:30	F 241	F241 1. All residents who require feeding assistance are at risk. Staff were educated on ensuring residents do not wait greater than 25 minutes for their meal. This was educated at the time of discovery of the deficient practice. 2. The DNS will in-service staff no later than February 1, 2013 to ensure residents do not wait greater than 25 minutes for their meal. 3. The DNS or designee will audit random meal services four times a week for four weeks then monthly for 3 months to ensure residents do not wait an extended time period for meals. Results of audits will be reported by the DNS and discussed at monthly QA&A meeting for further review and recommendations and/or continuation/discontinuation of audit. 4. February 7, 2013	2/1/13	

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F 241	Continued From page 3 p.m. of the meal service revealed: *Two tables of six residents who required feeding assistance were seated for the meal service. *The meal was served to all residents who required feeding assistance before 12:20 p.m. *One certified nurse assistant (CNA) began to feed one resident at one table of six at 12:20 p.m. *No other CNAs sat down to help feed other residents who had received their meal at those two tables until 12:30 p.m. Observation on 1/8/13 at 5:45 p.m. in the main dining room revealed two tables of residents who required feeding assistance had just begun to eat with the help of two CNAs. All other independent residents who sat at other tables in the dining room were just finishing their meals or were leaving. Interview with the director of nursing on 1/9/13 at 3:15 p.m. confirmed: *Residents who required feeding assistance had always been served last. *She had no expectation of an appropriate length of time for those residents to be served and assisted. Review of Golden Living Centers notices booklet given to residents upon admission stated the resident has the right to be treated with dignity and respect in full recognition of individuality.	F 241			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	F253 1. All residents at risk. Corrections to the environment are as follows: Caulking around toilets have been replaced in rooms 202, 218 and 220 and around sink in room 201. The grouting between the	2/7/13	

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F 253	Continued From page 4 This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation and interview, the provider failed to maintain the interior of the facility in a sanitary, orderly, and comfortable manner evidenced by: *Soiled caulking around toilets in the bathing room and in residents' rooms 202, 218, and 220. *Soiled caulking around the sink in residents' room 201. *Missing grout/caulking between the floor and the wall in the bathing room shower area. *Cracked flooring in the Alzheimer's Care Unit (ACU) bathroom. *Two of two residents room refrigerators (111 and 112) with expired and unlabeled food. *Soiled wall grab bars in resident room 111's bathroom. *Hot water registers bent and detached in the dining room and in residents' rooms 111, 112, and 300. *The wood railing around the base of the fireplace hearth was rough and bare wood was exposed on both angled corners creating a sharp edge. *The floor in resident room 300's bathroom was loose underneath the heater grate. *The toilet transfer arms were heavily soiled in resident room 111's bathroom. *The shower grab bar had a broken escutcheon plate (metal plate that covers the screws). Findings include: 1. Random observation on 1/8/13, 1/9/13, and interview on 1/9/13 at 10:30 a.m. with the maintenance supervisor (MS) revealed: a. Soiled caulking around the toilets in the bathing	F 253	floor and wall has been repaired in the shower area. The flooring in the Alzheimer's Care Unit bathroom has been repaired. The expired and unlabeled food in room 111 and 112's refrigerators has been removed. The grab bars in room 111 have been cleaned. The hot water registers in the dining room and rooms 111, 112 and 300 have been repaired. The wood railing around the fireplace has been repaired. The bathroom floor in Room 300 has been contracted for repair and the anticipated delivery date for materials is 2-5-13, with installation to be scheduled after delivery. The toilet transfer arms in room 111 have been cleaned. The attachment plate on the shower grab bar has been replaced. 2. Staff will be in-serviced by the ED no later than February 1, 2013 on reporting maintenance issues and entering problem into the facility's Building Engines program. 3. The ED or designee will conduct walking rounds on a weekly basis for six weeks. Walking rounds will include inspection of common areas and 10 rooms each week to check for any maintenance issues. ED will review the Building Engines maintenance log each week for six weeks to ensure maintenance issues are logged and followed up/repared. Results of audits will be reported by the ED and discussed at monthly QA&A meeting for further review and		

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F 253	Continued From page 5 room and in residents' rooms 202, 218, and 220. The MS agreed the caulking needed to be replaced around those toilets (photos 9, 19, 21 and 22). b. Soiled caulking around the sink in resident room 201. The MS stated he was in the process of trying to replace all the sinks. He was not aware the caulking around that sink was in such bad condition (photo 18). c. The grout/caulking between the shower floor in the bathing room and the wall was missing. The MS stated he was not aware the grout had come out of that area (photo 24). d. The floor in the ACU bathroom by the dining room was cracked. The MS stated he was aware the floor was cracked (photo 23). e. The residents' refrigerators in rooms 111 and 112 contained outdated and unlabeled food. The refrigerator thermometer in room 111 was broken. The freezer compartment of resident room 112's refrigerator had a large amount of ice build-up. The door to the freezer compartment was not able to be closed. The MS stated he was in charge of monitoring for outdated and unlabeled food. He stated the nurses monitored the refrigerator temperatures. He did not have a regular schedule of when he checked the refrigerators (photo 15). f. The grab bar in the resident's bathroom for room 111 was heavily soiled, and debris could be scraped off with a fingernail. The MS agreed the grab bar was very soiled (photo 13). g. The hot water registers in the dining room and residents' rooms 111, 112, and 300 were bent and had hanging loose parts. The MS stated he was constantly trying to repair the registers (photo 5, 7, 14, and 16). h. The wood railing around the base of the	F 253	recommendations and/or continuation/discontinuation of audit. 4. February 7, 2013		

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F 253	Continued From page 6 fireplace hearth in the dining room was chipped, and bare wood was visible on both angled corners. That made those areas uncleanable and also could have caused skin tears to residents lower legs. The MS stated he would have to come up with a different method to protect the tile hearth from wheelchairs (photo 6). i. The flooring in resident room 300's bathroom was curling upward underneath the heater grate. The MS agreed that flooring was loose. There was debris between the loose flooring and the wall. He stated he was not aware of the condition of the floor (photo 8). j. The toilet transfer arms in resident room 111 were heavily soiled. The MS agreed those transfer arms appeared to not have been cleaned properly (photo 17). k. The grab bar in the shower area of the bathing room had an escutcheon plate that was not attached and exposed the mounting screws. The MS stated he was not aware that plate had come loose. He agreed there was rust present on the screws (photo 11).	F 253			
F 280 SS=G	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280	F280 1. All residents are at risk. Resident 3 and 8's care plan has been updated. Resident 17 is no longer in the facility. 2. The DNS will in-service nursing and the Interdisciplinary Team (IDT) on ensuring plans of care are updated for resident care needs, including resident to resident altercations, self-administration of medications and pressure ulcers. The policy and procedure will be reviewed and review will include care plan creation,	2/7/13	

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F 280	<p>Continued From page 7</p> <p>disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, record review, interview, and policy review, the provider failed to ensure residents' care plans for 3 of 13 sampled residents (3, 8, and 17) were developed, reviewed, and revised for appropriate problems, goals, and approaches. Findings include:</p> <p>1. Review of resident 8's medical record revealed he had been admitted on 10/12/12. The record revealed he had been admitted with stage 1 pressure ulcers on both heels. Upon admission the pressure ulcers had not been care planned and the physician had not been notified of the stage 1 pressure ulcers. They had not been addressed as pressure ulcers until they had reached a stage 4 in severity. Refer to F314, finding 1.</p> <p>2. Review of the following investigation reports sent to the Department of Health for resident-to-resident abuse revealed: *On 9/20/12 resident 17 had attempted but it had not been substantiated that resident 17 had slapped another resident. *Staff had been educated to monitor the two</p>	F 280	<p>review, revision and resolution. Examples cited in this deficiency will be shared. In-servicing will occur no later than February 1, 2013.</p> <p>3. The DNS or designee will audit four random plans of care each week for four weeks and then monthly for three months to ensure plan of care is accurate and up to date. Results of audits will be reported by the DNS and discussed at monthly QA&A meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>4. February 7, 2013</p>		

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F 280	<p>Continued From page 8</p> <p>residents in question to ensure no inappropriate behaviors had occurred between them. *On 12/16/12 at 6:00 p.m. resident 17 had slapped another resident across the face.</p> <p>Review of resident 17's care plan last updated on 1/7/13 revealed no additions to the care plan in response to the above incidents of resident-to-resident abuse.</p> <p>Review of the provider's May 2001 abuse reporting policy revealed steps were to be taken to prevent recurrence to include care planning and documentation.</p> <p>Interview on 1/10/13 at 9:40 a.m. with the Minimum Data Set (MDS) coordinator confirmed the care plan should have but had not been updated to address resident 17's resident-to-resident abuse. Surveyor: 32333 Preceptor: 26632</p> <p>2. Two of twenty-two sampled resident's (10 and 18) had orders to self-administer medications per the director of nursing. Self-administration of medications had not been care planned for residents 10 and 18. Refer to F176.</p> <p>Surveyor: 32355 Preceptor: 20031</p> <p>3. Review of resident 3's medical record revealed he had been admitted on 12/17/04.</p> <p>Review of resident 3's treatment assessment record (TAR) for month of January 2013 revealed: **Complete skin assessment weekly and document impaired skin integrity on TAR or wound evaluation flow sheet. Order date:</p>	F 280			

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F 280	Continued From page 9 8/19/2012." *His skin was scheduled to be checked weekly at 8:00 p.m. *His TAR reflected that initials had been placed by that scheduled nurse on 1/6/13 that his skin assessment had been done. *No documentation had been found on the condition of his skin. Review of resident 3's comprehensive care plan dated 10/29/12 revealed: *Focus: resident was at risk for pressure ulcers. Date initiated 11/9/10. *Goal: resident would maintain skin integrity through 1/23/13. *Preventions included: -Monitor extremities and report changes. -Promptly clean and dry skin after each incontinent episode. -Weekly skin assessment per nursing, refer to TAR. *It did not address current skin changes to his right heel. *It did not address any repositioning to be done when recently ill with influenza A. *It did not address the heel lift boot on his right foot.	F 280			
F 281 SS=E	Refer to F314 finding 3. 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:	F 281	F281 1. All residents are at risk. Resident 16 has a current physician order for pressure ulcer treatment. The facility identified the failure to get an X-ray for Resident 4 on 11/12/12 (prior to survey) and corrective action and change of procedure was	2/7/13	

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F 281	<p>Continued From page 10</p> <p>Surveyor: 26632</p> <p>Based on record review, interview, and policy review, the provider failed to ensure:</p> <p>*One of four residents (16) had a physician's order for the treatment of a pressure ulcer.</p> <p>*One of three residents (8) had documentation to support insertion of a catheter.</p> <p>*One of fourteen residents (4) had an Xray performed in a timely manner.</p> <p>Findings include:</p> <p>1. Review of resident 16's interdisciplinary notes revealed a stage two pressure ulcer had been identified to her left bunion (area to side of great toe) on 1/3/13.</p> <p>Review of resident 16's January 2013 treatment administration record revealed a treatment to the left bunion that had been initiated on 1/3/13. That treatment was to place a Medipore pad dressing to the left bunion until healed.</p> <p>Review of resident 16's physician's orders revealed no order for the application of the above dressing.</p> <p>Interview on 1/9/13 at 3:10 p.m. with the director of nursing (DON) revealed:</p> <p>*There was a wound care protocol that was followed for all wounds and pressure ulcers.</p> <p>*There was no standing order from resident 16's physician or the provider's medical director that authorized the use of any of the wound care protocols.</p> <p>Interview on 1/9/13 at 3:30 p.m. with registered nurse C and the DON revealed:</p> <p>*She had documented the pressure ulcer on</p>	F 281	<p>implemented at that time. Resident 8 no longer resides in the facility.</p> <p>2. The DNS will in-service nurses no later than February 1, 2013 on ensuring obtainment of physician orders for treatments, including pressure ulcers, and appropriate justification and documentation needed for insertion of a catheter. The process for obtaining X-rays was changed and relayed to nurses on 11/15/12 and will be reeducated as well.</p> <p>3. The DNS or designee will audit four random resident charts each week to ensure physician orders are obtained for treatments, there is appropriate justification and documentation for catheter use and X-rays are obtained when ordered. Audits will be weekly for four weeks and then monthly for three months. Results of audits will be reported by the DNS and discussed at monthly QA&A meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>4. February 7, 2013</p>	

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F 281	Continued From page 11 1/3/13. *Another nurse had actually called the physician for the wound care order. *The DON agreed the order should have been documented when it had been obtained. *The DON agreed there was no documentation the physician had agreed to the wound care order. Surveyor: 28057 2. Resident 8 had been admitted on 10/12/12 with out a urinary catheter. A catheter had been inserted on 10/13/12. There was no documentation to support the use of a catheter. Refer to F514, finding 2. Surveyor: 29162 3. Review of resident 4's medical record revealed a physician's order dated 1/8/13 for an x-ray of her left knee. That x-ray had not been done. Refer to F508.	F 281			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, record review, policy review, and interview, the provider failed to	F 309	F309 1. All residents are at risk. Resident 3 is receiving appropriate care and treatment for their pressure ulcers. Resident 8 no longer resides in the facility. 2. The DNS will in-service the IDT and all staff no later than February 1, 2013 on the policy of skin assessments, pressure ulcer prevention interventions, and pressure ulcer care and treatment, including reporting upon discovery. Examples cited in this deficiency will be reviewed.	2/7/13	

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F 309	<p>Continued From page 12</p> <p>ensure the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care were developed and carried out for two of four sampled residents (3 and 8) with pressure ulcers. Findings include:</p> <p>1. Review of resident 8's medical record revealed he had been admitted with stage 1 pressure ulcers on both heels. Upon admission the pressure ulcers had not been care planned and the physician had not been notified of the stage 1 pressure ulcers. They had not been addressed as pressure ulcers until they had reached a stage 4 in severity. Refer to F314, finding 1.</p> <p>Surveyor: 32355 Preceptor: 20031</p> <p>2. Review of resident 3's medical record revealed:</p> <p>*He had recently been ill with influenza A. *He had recently experienced a decline in his condition. *Therapy had been ordered to help him improve his strength. *He was at risk of pressure ulcers and had developed a stage II pressure ulcer on his right (R) heel. *There were conflicting interviews and a lack of documentation to support when the stage II pressure ulcer had been found. *There was no documentation in the interdisciplinary notes until 1/8/13 to support the presence of a stage II pressure ulcer and medical doctor (MD) involvement. *His comprehensive care plan and treatment assessment record (TAR) had not been updated</p>	F 309	<p>3. The DNS or designee will audit four random resident charts each week to ensure skin assessments are completed and pressure ulcers have appropriate treatments, notification and timely documentation. Audits will continue for four weeks and then will be monthly for three months. Results of audits will be reported by the DNS and discussed at monthly QA&A meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>4. February 7, 2013</p>		

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F 309	Continued From page 13 until 1/8/13 to support the presence of the stage II pressure ulcer to his (R) heel. *No repositioning, pressure relieving measures, daily documentation, therapy and MD involvement had been found until 1/8/13.	F 309			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, interview, record review, and policy review, the provider failed to render necessary care and treatment to prevent a pressure ulcer or the worsening of a pressure ulcer for two of four sampled residents (3 and 8) with a pressure ulcer. Findings include: 1. Review of resident 8's medical record revealed he had been admitted on 10/12/12. Review of resident 8's 10/12/12 clinical health status assessment form revealed: *The resident's Braden score had been a 12. *The resident was at high risk for a pressure ulcer. *Section B for skin conditions had been	F 314	F314 1. All residents are at risk. Resident 3 is receiving appropriate care and treatment for their pressure ulcer. Resident 8 no longer resides in the facility. 2. The DNS will in-service the IDT and all staff no later than February 1, 2013 on the policy of skin assessments, pressure ulcer prevention interventions, and pressure ulcer care and treatment, including reporting upon discovery. Examples cited in this deficiency will be reviewed. 3. The DNS or designee will audit four random resident charts each week to ensure skin assessments are completed and pressure ulcers have appropriate treatments, notification and timely documentation. Audits will continue for four weeks and then will be monthly for three months. Results of audits will be reported by the DNS and discussed at monthly QA&A meeting for further review and recommendations and/or continuation/discontinuation of audit. 4. February 7, 2013	2/7/13	

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F 314	<p>Continued From page 14 completed.</p> <p>*The resident had a 0.5 centimeter (cm) slightly red area on the side of the left foot by the heel.</p> <p>*The resident had a 1.0 cm slightly red area on the side of the right foot.</p> <p>*Both were on the outer aspects of the foot.</p> <p>*The resident had been wearing foam foot/heel boots from the hospital.</p> <p>Review of the resident's 10/22/12 care plan revealed:</p> <p>*A focus that stated the resident had been at risk for pressure ulcers related to:</p> <ul style="list-style-type: none"> -Activities of daily living functional status. -Non-weight bearing status to the left leg. -Bowel incontinence. <p>*The goal was the resident would maintain skin integrity through 1/18/13.</p> <p>*Preventions included:</p> <ul style="list-style-type: none"> -Refer to the treatment administration record (TAR) for current treatment to surgical wounds to the left leg. -Reposition the resident every two hours. -Gel foam wheelchair cushion and alternating air mattress were to be in-use. -Monitor extremities and report changes. -Promptly clean and dry skin after each incontinent episode. -Complete a weekly skin assessment by nursing/refer to the TAR. <p>*It had not addressed the reddened areas on the resident's feet as stage one pressure ulcers.</p> <p>Review of the Minimum Data Set 3.0, section M, skin conditions, revealed a stage one pressure ulcer was a non-blanchable localized red area usually over a bony prominence.</p>	F 314			

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F 314	<p>Continued From page 15</p> <p>Review of the resident's October 2012 handwritten TAR revealed:</p> <ul style="list-style-type: none"> *No pillow was to have been placed under the left leg. *Heel protectors were to be checked every shift. *A skin assessment was to have been completed every Monday. *It had documentation entered for 10/12/12 and 10/13/12 only. *A new TAR was computer generated and documentation had been started on 10/13/12. <p>Review of the resident's computer printed TAR from 10/12/12 through 10/31/12 revealed:</p> <ul style="list-style-type: none"> *Heel protectors to both feet were to be checked every shift starting on 10/13/12. *Both feet were to have been monitored for breakdown twice every day. *That had not been initiated until 10/19/12, seven days after the resident had been admitted. *Complete a weekly skin assessment and document impaired skin integrity on the TAR or a wound evaluation sheet. *No pillow was to have been placed under the resident's left leg. <p>Review of resident 8's TAR from 11/1/13 through 11/30/12 revealed:</p> <ul style="list-style-type: none"> *No pillow was to have been placed under the resident's left leg *No change in the above treatments from 10/31/12 until 11/14/12. *On 11/14/12 heel protectors had been discontinued for both feet. *Measurements for pressure ulcers on both heels every Tuesday had been added on 11/14/12. *Those measurements were to have been entered on a wound flow sheet. 	F 314			

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F 314	<p>Continued From page 16</p> <p>*The pressure ulcers were to have been monitored every day.</p> <p>*On 11/14/12 Rook boots were added to have been applied to both feet when the resident had been up in the wheelchair.</p> <p>*On 11/27/12 monitoring and measuring of the left heel pressure ulcer had been discontinued.</p> <p>*Monitoring of the site of the old pressure ulcer on the left heel twice every day had been added on 11/27/12.</p> <p>Review of resident 8's 12/1/12 through 12/31/12 TAR revealed:</p> <p>*On 12/19/12 it had been documented the skin of the left heel was non-tender, intact, and healed.</p> <p>*The pressure ulcers were to have been monitored everyday.</p> <p>*Rook boots were to have been applied to both feet when the resident had been up in the wheelchair.</p> <p>*Monitoring of the site of the old pressure ulcer on the left heel twice everyday had been continued.</p> <p>*No pillow was to be placed under the resident's left leg.</p> <p>*Weekly measurements for the right heel ulcer continued on the wound flow sheet.</p> <p>Review of resident 8's 1/1/13 through 1/31/13 TAR revealed:</p> <p>*Rook boots were to be applied to both feet when the resident had been up in the wheelchair.</p> <p>*Monitoring of the site of the old pressure ulcer on the left heel twice everyday had been continued.</p> <p>*No pillow was to be placed under the resident's left leg.</p> <p>*Weekly measurements for the right heel ulcer continued on the wound flow sheet.</p>	F 314			

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F 314	<p>Continued From page 17</p> <p>Review of resident 8's interdisciplinary progress notes (IPN) revealed:</p> <p>*From 10/12/12 through 10/24/12 no documentation had been entered in regards to the status of the resident's heels.</p> <p>*On 10/25/12 at 9:30 p.m. RN N documented the resident's left foot had a reddened area on the outer side of the heel 0.5 cm and circular in shape.</p> <p>*An area surrounding the reddened area was 1.0 cm by 0.5 cm that was also red.</p> <p>*The left ankle joint had a 1.0 cm dark pink area.</p> <p>*None of those areas had been open.</p> <p>*The resident had complained of pain when it was touched.</p> <p>*The nurse had communicated to the director of nursing (DON) and the day nurse the need to evaluate the resident for Rook boots in place of the sponge boots.</p> <p>*On 11/14/12 at 10:00 p.m. RN N documented Rook boots had been on when the resident had been up and had been off when in bed.</p> <p>*On 11/15/12 at 11:33 a.m. the dietician entered documentation of a stage 4 pressure ulcer on both heels.</p> <p>*The dietician added supplements and recommended a multiple vitamin to address the pressure ulcers.</p> <p>*On 11/15/12 at 2:56 p.m. it had been documented by nurse D new orders had been received from the resident's physician to start the pressure ulcer protocol.</p> <p>On 11/14/12 a wound evaluation chart had been started for resident 8 and revealed:</p> <p>*Stage 4 pressure ulcers to the right and left heels.</p> <p>*The resident had been admitted with stage 1</p>	F 314			

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F 314	<p>Continued From page 18</p> <p>reddened areas to both heels. *Both heels now had black scabbed areas. *The right heel ulcer measured 1.0 cm by 0.8 cm. *The left heel ulcer measured 0.4 cm by 0.4 cm.</p> <p>The resident's care plan updated on 11/14/12 revealed: *As a focus unstageable pressure ulcers had been declared to both heels. *The goals were to have the ulcers healed by 1/18/13, and no other ulcers were to have occurred. *Interventions had been added that included: -Check TAR for treatments as ordered. -Measure pressure ulcers weekly and document on the wound evaluation flow sheet. -Referral to physical therapy for wound evaluation. -Rooke boots to be worn when up in wheelchair. *No Rooke boots or socks to be worn in bed.</p> <p>The provider's undated pressure ulcer checklist had revealed: *The nurse who discovered the pressure ulcer was to have started the necessary paperwork. *The physician was to have been notified and orders received for medications and treatments to address the pressure ulcer. *The problem was to have been added to the care plan within 24 hours. *Notify dietary about the skin problem.</p> <p>Review of the provider's 2006 prevention of pressure ulcer policy revealed: *The purpose had been to prevent skin breakdown and the development of pressure ulcers. *Documentation was to have included notification</p>	F 314			

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F 314	<p>Continued From page 19</p> <p>of the physician of a new pressure ulcer when it was identified.</p> <p>*Care planning was to have identified the problem, treated the underlying problem, and listed possible risks and complications.</p> <p>*Necessary monitoring and observation was to have been included.</p> <p>Interview on 1/9/13 at 2:20 p.m. with the DON confirmed:</p> <p>*She would have expected the pressure areas on resident 8's heel to have been added to the care plan when the resident had been admitted.</p> <p>*All of the nurses were responsible to update the care plans as needed.</p> <p>*Resident 8 was at high risk for a pressure ulcer to have developed.</p> <p>*She had believed the correct interventions had been in place on admission for prevention of pressure ulcers.</p> <p>*The care plan had not reflected what had been documented in the clinical assessment in regards to the resident's heels.</p> <p>Interview on 1/9/13 at 3:40 p.m. with the DON further confirmed documentation for the pressure ulcers would have been found on weekly skin evaluation sheets, on the TAR, or in the IPN notes. No other documentation existed in regards to skin/pressure ulcers.</p> <p>Surveyor: 32355 Preceptor: 20031 2. Review of resident 3's medical record revealed: *He had been admitted on 12/17/04 *He had diagnoses of alcoholism, induced dementia.</p>	F 314			

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F 314	<p>Continued From page 20</p> <p>*He had cognitive impairment, usually understood, but did not verbalize (talk).</p> <p>*He had been diagnosed with influenza A on 1/3/13.</p> <p>*On 1/8/13 it had been reported to the medical doctor (MD) he had a stage II pressure ulcer to his right (R) heel.</p> <p>Observation on 1/7/13 at 3:30 p.m. of resident 3 revealed:</p> <p>*He was ambulating down the hallway with an unidentified certified nursing assistant (CNA).</p> <p>*He was wearing a heel lift boot on his right foot.</p> <p>Random observation from 1/7/13 at 3:20 p.m. through 1/8/13 at 9:05 a.m. revealed:</p> <p>*He had a regular mattress on his bed.</p> <p>*There was no pressure relieving mattress or air overlay on his bed.</p> <p>*There was no pressure relieving cushion placed in his recliner.</p> <p>Interview on 1/7/13 at 3:45 p.m. with certified nursing assistant (CNA) F revealed:</p> <p>*He had a pressure ulcer to his right heel and that was why he had the heel lift boot.</p> <p>*He had recently been ill with influenza A.</p> <p>*"He does not position well and it is hard to keep pressure off his heels as he pulls his legs up in bed."</p> <p>*Physical therapy (PT) had put the heel boot on that day.</p> <p>Observation of resident 3 on 1/8/13 at 9:00 a.m. revealed:</p> <p>*He was sitting in a recliner in the Alzheimers care unit (ACU) day room with his feet elevated.</p> <p>*The heel lift boot was on his (R) foot.</p>	F 314		

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F 314	<p>Continued From page 21</p> <p>*Minimum data set (MDS) coordinator registered nurse (RN) removed his boot, viewed the area, and measured a circular area on his (R) foot. That circular area was a wound to his (R) heel was reddened, and was fluid filled.</p> <p>*No vocalization nor signs and symptoms (s/s) of pain had been observed from resident 3.</p> <p>Interview on 1/8/13 at that same time with the MDS coordinator regarding the above observation with resident 3 revealed:</p> <p>*She stated the pressure ulcer had been found last night.</p> <p>*She was unsure who had put the heel lift boot on. "But it was a good idea as it keeps pressure off it."</p> <p>Review of resident 3's physical therapy assistant (PTA) progress note dated 1/7/13 at 2:07 p.m. revealed:</p> <p>**Pt has a closed blister on (R) heel which a pressure relief boot has been placed to decrease any further break down."</p> <p>**PT and PTA have discussed plan of care (POC) and goals with a direct supervisory visit. Plan to continue."</p> <p>Interview on 1/8/13 at 2:45 p.m. and again on 1/10/13 at 7:50 a.m. with the PTA revealed:</p> <p>*On 1/7/13 they had been informed by the CNA at the time of his therapy treatment he had a pressure ulcer to his (R) heel.</p> <p>*The wound had been found over the weekend.</p> <p>*Therapy had checked the wound on Monday and had recommended an air bed or protective boot to relieve pressure.</p> <p>*They had called maintenance and had been informed the facility did not have anymore air</p>	F 314		

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F 314	<p>Continued From page 22</p> <p>mattresses. The heel lift boot has then been placed on his (R) foot to relieve pressure.</p> <p>*As of today his heel boot was to be removed with ambulation (walking).</p> <p>*All of the above had been reported to the charge nurse and the ACU coordinator on 1/7/13 and today.</p> <p>**"All changes are reported to the charge nurse."</p> <p>Review of resident 3's treatment assessment record (TAR) on 1/8/13 at 8:00 a.m. revealed:</p> <p>*His skin was to have been checked weekly on Sundays at 8:00 p.m.</p> <p>*His TAR reflected that initials had been placed by that scheduled nurse on 1/6/13 that his skin assessment had been done.</p> <p>*No documentation had been found on the condition of his skin.</p> <p>Review of the ACU bath schedule had revealed:</p> <p>*He was to have a bath on Sundays during the daytime.</p> <p>Interview on 1/9/13 at 2:30 p.m. with CNAs I and J revealed charge nurses did not check any residents skin during their baths unless a problem was reported to them by the CNA.</p> <p>Interview on 1/9/13 at 5:05 p.m. with RNs C and K revealed:</p> <p>*Weekly skin assessments were done on the evening shift from 5:00 p.m. to 10:00 p.m.</p> <p>*New wounds were to have been documented on the back of the resident's TAR.</p> <p>*The nurses had a checklist that was to be initiated and when completed was to have been given to the director of nurses (DON).</p> <p>*Items on the checklist included: notification of</p>	F 314		
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F 314	<p>Continued From page 23 the medical doctor (MD), dietary, CNA, and family. *All of those items were to have been documented in the interdisciplinary progress notes by the charge nurse.</p> <p>Review of resident 3's interdisciplinary progress notes from 1/3/13 through 1/8/13 revealed: *1/3/13 He had been diagnosed with influenza A. -Tamiflu had been started. -He had eaten in his room. *1/4/13 He had been resting soundly all shift. -Tylenol had been given for fever. *1/8/13 Was the first note written by ACU director that addressed his stage II pressure ulcer to his (R) heel. -Orders had been received from his MD to start pressure ulcer protocol. *No documentation had addressed: -Stage II pressure ulcer to his (R) heel prior to 1/8/13. -Therapy's involvement with the pressure ulcer and placement of the heel lift boot.</p> <p>Review of resident 3's wound evaluation flow sheet dated 1/8/13 revealed: *Stage II pressure ulcer on his (R) heel. *Appearance of wound: -measured 4.0 width and 3.8 diameter, fluid filled, and margins were intact.</p> <p>Review of resident 3's comprehensive care plan dated 10/29/12 revealed: *Resident 3 was at risk for pressure ulcers. Date initiated had been 11/9/10. *It had not addressed any repositioning when recently ill with influenza A nor the heel lift boot on his (R) foot. *There was no recommendations from therapy for</p>	F 314			

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F 314	<p>Continued From page 24</p> <p>when his heel lift boot was to be on and off. *There were no documentation dietary had been notified or involved of his (R) heel pressure ulcer.</p> <p>Review of resident 3's updated comprehensive care plan dated 1/7/13 and 1/8/13 revealed: *No changes had been made to the "at risk for pressure ulcer" focus area. *A new focus area had been added to his comprehensive care plan dated 1/8/13. -Focus: "Stage 2 pressure ulcer declared to right heel. At risk for further pressure ulcers." Date initiated had been 1/8/13. *Goals: -"Ulcer will be healed by Target date: 4/2/13." -"No further pressure ulcers will develop." *Preventions had addressed: -A repositioning schedule at least every two hours. Date initiated: 1/8/13. -PT involvement. *Preventions had not addressed: -The heel lift boot to his (R) foot. -Any pressure relieving devices for his bed or recliner.</p> <p>Review of resident 3's TAR revealed: *The pressure ulcer to his (R) heel: -Was to be measured weekly and documented. -Was to be checked daily. **"Heel lift boot to right foot at all times until pressure ulcer healed." **"Therapeutic air mattress." *All of the above had been initiated on 1/8/13.</p> <p>Interview on 1/9/13 at 9:45 a.m. with the DON revealed: *She clarified resident 3 had been recently experiencing a decline in condition. No reason for</p>	F 314		

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F 314	<p>Continued From page 25 the decline had been found. *Therapies had been ordered to help the resident "get better." *Resident 3 had spent most of his time in his room during his recent illness with influenza A. *She was unsure if he had been repositioned every two hours while he had been ill. *Repositioning was not required to be put on the care plan. Every two hours was their standard repositioning schedule. *The pressure ulcer to his (R) heel had been reported to her on Monday, 1/7/13. She had visited with nursing staff to initiate the process at that time. No documentation to support that process had been found. *She confirmed PT had put the heel lift boot on his (R) foot on Monday, 1/7/13. *She confirmed that therapy had been notified by nursing staff of his (R) foot pressure ulcer, but no documentation had been found. *She had the MDS coordinator check the wound yesterday (Tuesday). *She agreed there had been no documentation found in regards to the pressure on his (R) heel. *The pressure ulcer checklist was only for their own personal use. *She stated they had no policy on nursing documentation. The nurses were to chart by exception, change of condition, or as required by Medicare.</p> <p>Policy (undated) review on nursing documentation revealed: *No policy on MD notification. *They were to follow the nursing standard.</p> <p>Review of the DONs undated pressure ulcer checklist revealed:</p>	F 314			

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F 314	Continued From page 26 **Number 1: Professional nurse discovering the pressure ulcer is responsible to start the necessary paperwork and orders." *Number 2: "Notify the MD that resident had pressure ulcer."	F 314			
F 431 SS=D	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. 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	F 431	F431 1. All residents are at risk. All medication and treatment carts are locked when not attended. 2. The DNS will in-service nurses and medication aides no later than February 1, 2013 on the requirement that medication and treatment carts must be locked when not attended. 3. The DNS or designee will perform audits four times weekly at varying times to ensure medication and treatment carts are locked when not attended. Audits will continue weekly for four weeks and then monthly for three months. Results of audits will be reported by the DNS and discussed at monthly QA&A meeting for further review and recommendations and/or continuation/discontinuation of audit. 4. February 7, 2013	2/7/13	

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F 431	Continued From page 27 be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Preceptor: 26632 Based on observation and interview, the provider failed to ensure one of two treatment carts (east) remained locked when unattended. Findings include: 1. Observation on 1/8/13 at 11:45 a.m. of the east treatment cart revealed: *The cart was left unattended and unlocked in the hallway while registered nurse D provided treatment to a resident. *The treatment cart drawers were easily opened when pulled. *The treatment cart was left unattended for approximately twenty minutes. *Staff members and residents walked by the unlocked treatment cart. *The treatment cart contained: Clorox wipes, Icy hot patches, Biofreeze gel, Selsun Blue shampoo, lidocaine, Safe Gel ointment, Nystatin powder, Nystatin/Triamcinolone cream, Triamcinolone cream, and Hydrocortisone cream. Interview with the director of nursing on 1/9/13 at 3:15 p.m. confirmed her expectation would have been for the medication cart to have been locked when unattended.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441	F441 1. All residents are at risk. Appropriate Personal Protective Equipment (PPE) is being provided. New laundry carts and	2/7/13	

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F 441	<p>Continued From page 28</p> <p>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 actions related to infections.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 441	<p>linen covers were ordered and replaced the existing carts. A new door for the laundry room was ordered on 1/18/13 and will be installed when it arrives (estimated time is 4-6 weeks). The towel stand in the bathing room has been replaced and the tape has been removed from the toilet transfer arms. Residents 3 and 6 have recovered from their illness.</p> <p>2. The DNS will in-service all staff no later than February 1, 2013 on the policy and procedure related to infection prevention and control, including isolation protocols, and appropriate hand hygiene and glove use. Examples cited in this deficiency will be shared. The policy and procedure on dressing changes will be reviewed with nurses. Additional education will include education to housekeeping & laundry department on ensuring their equipment is maintained in a sanitary manner and the use of coverings on their laundry delivery cart.</p> <p>3. The DNS or designee will perform weekly audits to ensure: PPE is used as warranted; gloves are not stored in pockets; laundry carts are clean and in good repair and laundry has an impervious cover on it when transported. The audit will also include observation of a dressing change twice weekly to ensure it is performed per policy. Audits will be weekly for four weeks and then monthly for three months. Results of audits will be reported by the DNS and discussed at monthly QA&A meeting for further</p>		

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F 441	Continued From page 29 Surveyor: 32355 Surveyor: 26632 Based on observation, record review, interview, and policy review, the provider failed to ensure: *Isolation protocols were in place and were followed for two of two sampled residents (3 and 6) in droplet isolation. *Established policies to prevent the spread of influenza in the Alzheimer's Care Unit (ACU) had been followed. *Five of nine laundry carts were maintained in a cleanable manner. *One of two laundry covers was maintained to prevent contamination of clean linen. *The door to the laundry room was maintained in a cleanable and safe manner. *Clean resident clothing was delivered to prevent cross-contamination. *One of one wire towel stand in the bathing room was maintained in a cleanable manner. *Tape had not been used on one of two toilet transfer arms. *Gloves were not stored in one of one registered nurse (RN) C uniform pocket for use during one of one tubing feeding. *One of one dressing change for resident 4 had been completed in a sanitary manner. Findings include: Surveyor 32355 Preceptor: 26632 1. Observation on 1/7/13 at 3:15 p.m. revealed: *Upon entering the ACU certified nursing assistant (CNA) F informed this surveyor there was influenza A in the ACU. *She asked if we would like a mask to wear.	F 441	review and recommendations and/or continuation/discontinuation of audit. 4. February 7, 2013	

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F 441	<p>Continued From page 30</p> <ul style="list-style-type: none"> *No face masks were located outside the doors to the ACU. *Masks had been placed on the handrail down the hall and around the corner leading to the ACU dining room. *No resident rooms had been identified for those residents that had an Influenza A diagnosis. <p>Surveyor 26632 Observation on 1/7/13 at 5:30 p.m. revealed:</p> <ul style="list-style-type: none"> *A sign on the door to the ACU stated there was Influenza A in the ACU. *There were no instructions as to what precautions should have been used. *Upon entering the ACU no face masks were available. *CNA F was asked if any face masks were available, and she located the face masks on the handrail down the hall and around the corner leading to the ACU dining room. *When CNA F was asked why she was not wearing a face mask she stated "I've been exposed for a few days so I don't need it." *There was no precaution signage on any of the residents' rooms who had a diagnosis of influenza A. *There was no personnel protective equipment outside of any resident's rooms. *No staff in the ACU were noted to use any precautions other than standard precautions while assisting residents with eating. <p>Random observation on 1/8/13 at various times from 10:00 a.m. to 4:00 p.m. revealed no face masks were available for use prior to entry or inside of the ACU.</p> <p>Observation on 1/8/13 at 3:30 p.m. of RN E and</p>	F 441			

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F 441	<p>Continued From page 31</p> <p>CNA F revealed: *RN E entered resident 6's room to give him medication. *RN E did not have a mask on and did not wear gloves. *Resident 6 requested to get out of bed. *RN E asked CNA F to assist her with resident 6. *CNA F had a mask on and put gloves on. *RN E did not put a mask on but did put gloves on. *Resident 6 was actively coughing during the transfer from the bed to the wheelchair.</p> <p>Interview on 1/8/13 at 2:30 p.m. with RN/director of clinical education B revealed: *The first case of influenza A had been identified on 1/2/13 for resident 16. *The subsequent cases of influenza A had occurred on 1/3/13 for resident 3 and on 1/7/13 for resident 19. *Two other residents 6 and 15 also had symptoms of influenza A but had not been tested per family requests. *Resident 15 had died in the facility on 1/5/13. *One staff nurse had symptoms of influenza A but had tested negative. She had been instructed to be off work until she had been without a fever for twenty-four hours. *Residents that had been identified with influenza A or with influenza A symptoms had been instructed to stay in their rooms, all physicians had been notified, and all families had been notified. *Masks were to have been wore when in rooms with those resident's with influenza A or with symptoms of influenza A. *She was not aware staff were not wearing masks during resident care.</p>	F 441		
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F 441	<p>Continued From page 32</p> <p>*She was not aware masks and other personal protective equipment was not available as stated in the provider's policy for droplet precautions.</p> <p>Observation on 1/8/13 at 4:00 p.m. revealed face masks had been placed on the railing just inside the ACU door. That was after RN/director of clinical education B had been notified no masks had been available at 2:30 p.m.</p> <p>Review of the ACU, CNA schedule for 12/27/12 through 1/9/13 revealed on 12/28/12, 12/31/12, 1/4/13, and 1/8/13 CNA O had been scheduled in the ACU from 6:00 a.m. to 2:00 p.m. and then had been assigned to the skilled unit (separate unit) from 2:00 p.m. to 6:00 p.m.</p> <p>Review of APIC Text of Infection Control and Epidemiology, 3rd Ed., 2009. Association for Professionals in Infection Control and Epidemiology, Inc., Washington, D.C., pg 18-3, revealed:</p> <p>*Droplet precautions prevent transmission of diseases caused by large respiratory droplets that are generated by coughing, sneezing, or talking. *Diseases transmitted by the droplet route include influenza. *Single rooms are preferred; however patients with the same disease may share a room. *Patients must be spatially separated by at least three feet. *Draw privacy curtains between patients. *Wear a surgical mask on room entry. *Handle items contaminated with respiratory secretions with gloves.</p> <p>Review of the provider's revised August 2012 infection control policy revealed</p>	F 441			

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F 441	Continued From page 33 *The objectives of the policy included: -Prevent, detect, investigate, and control infections in the facility. -Establish guidelines for implementing isolation precautions. -Establish guidelines for the availability and accessibility of supplies and equipment. *The type and duration of precautions for influenza was droplet precautions for five days. *Droplet precautions included: -Place the resident in a private room if possible. -When a private room was not available use a curtain and maintain three feet of space between residents. -Put on a mask when entering the room. -When possible dedicate the use of non-critical resident-care equipment such as a stethoscope, blood pressure cuff, or thermometer. -The provider would implement a system to alert staff and visitors to the type of precaution a resident required. *Initiating transmission-based precautions: -If a resident was suspected of, or identified as, having a communicable infectious disease the charge nurse would notify the infection control nurse and the resident's attending physician for appropriate transmission-based precautions. -When transmission-based precautions were implemented the infection control nurse would *Ensure that protective equipment was maintained outside the resident's room so everyone entering the room could access what they needed. *Post the appropriate notice on the room entrance door. *Ensure an appropriate linen hamper and waste container were placed in or near the resident's room.	F 441			

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F 441	<p>Continued From page 34</p> <p>*Discontinuing of isolation precautions: -Residents would remain on appropriate precautions until the attending physician or infection control nurse ordered them discontinued.</p> <p>Review of the Centers for Disease Control and Prevention. Prevention Strategies for Seasonal Influenza in Healthcare Settings last updated 12/19/11 http://www.cdc.gov/flu/professionals/infectioncontrol/rtc-facility-guidance.htm revealed: *When there was a confirmed or suspected influenza outbreak (two or more ill residents) *Once an outbreak has been identified, outbreak prevention and control measures should be implemented immediately. *Implement daily active surveillance for respiratory illness among ill residents, health care personnel, and visitors to the facility. Conduct active daily surveillance until at least one week after the last confirmed influenza case had occurred. *Implement Standard and Droplet Precautions for all residents with suspected or confirmed influenza. *Standard precautions include: -Wearing gloves if hand contact with respiratory secretions or potentially contaminated surfaces would be anticipated. -Wearing a gown if soiling of clothes with a resident's respiratory secretions was anticipated. -Changing gloves and gowns after each resident encounter and performing hand hygiene. *Droplet precautions should be implemented for residents with suspected or confirmed influenza for seven days after illness onset or until twenty-four hours after the resolution of fever and</p>	F 441			

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F 441	<p>Continued From page 35</p> <p>respiratory symptoms whichever was longer while a resident was in a health care facility.</p> <p>*Examples of droplet precautions include:</p> <ul style="list-style-type: none"> -Placing ill residents in a private room. If a private room not available place (cohort) residents suspected of having influenza residents with one another. -Wear a face mask (e.g., surgical or procedure mask) upon entering the resident's room. Remove the face mask when leaving the resident's room and dispose of the facemask in a waste container. -If resident movement or transport was necessary have the resident wear a face mask (e.g., surgical or procedure mask) if possible. -Communicate information about residents with suspected, probable, or confirmed influenza to appropriate personnel before transferring them to other departments. -These Precautions are part of the overall infection control strategy to protect against influenza in health care settings and should be used along with other infection control measures, such as isolation or cohorting of ill residents, screening employees and visitors for illness, furloughing ill health care personnel, and discouraging ill visitors from entering the facility. -Because residents with influenza may continue to shed influenza viruses while on antiviral treatment, infection control measures to reduce transmission, including following Standard and Droplet Precautions, should continue while the resident is taking antiviral therapy. This will also reduce transmission of viruses that may have become resistant to antiviral drugs during therapy. <p>*Implement active daily surveillance for respiratory illness among ill residents, health care</p>	F 441		
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F 441	<p>Continued From page 36</p> <p>personnel, and visitors to the facility until at least one week after the last confirmed influenza case had occurred.</p> <p>*Limit the number of large group activities and consider serving all meals in resident rooms if possible.</p> <p>*Restrict personnel movement from areas of the facility having illness to areas not affected by the outbreak.</p> <p>2. Observation on 1/8/13 at 8:00 a.m. revealed a linen cart being pushed down the hall by the nurses station. There were two uncovered pillows on the top of the linen cart. It was noted there was a large rip in the linen cart cover (photo 2).</p> <p>Observation and interview on 1/8/13 at 9:45 a.m. with laundry aide P revealed:</p> <p>*Five of nine laundry sorting carts had cracked or missing rubber bumpers (photos 3 and 4).</p> <p>*One of two linen cart covers had a ripped cart cover (photo 2).</p> <p>*The door to the laundry room was gouged and had rough edges making it uncleanable (photo 1).</p> <p>Observation on 1/9/13 from 9:00 a.m. through 4:00 p.m. revealed:</p> <p>*Laundry aide P had a small laundry cart that contained residents' personal laundry. That cart was covered by a cotton sheet. The sheet did not cover all the clothes in that cart (photo 12).</p> <p>*A wire stand in the bathing room that held clean towels for resident bathing. There were several areas of rust on the surface of that stand making it uncleanable (photo 10).</p> <p>*Red electrical tape had been placed on the hand grips of the toilet transfer arms in resident bathroom 203. That bathroom was shared by two</p>	F 441			

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F 441	<p>Continued From page 37 residents' rooms. The tape made that surface uncleanable (photo 20).</p> <p>Interview on 1/9/13 at 4:30 p.m. with the housekeeping/laundry supervisor revealed: *She was aware of the laundry sorting carts and the linen cart cover. She stated the carts were extremely old, and she was not sure if replacement parts could be ordered. She stated the linen cart cover had been ripped for some time. *She thought a sheet was sufficient covering over residents' personal clothing. She agreed that sheet was not resistant to moisture and air particles and did not cover all the contents of the linen cart. *She agreed tape should not have been placed on the toilet transfer arms. *She stated she was not aware of the condition of the wire stand in the bathing room.</p> <p>Surveyor: 28057 3. Observation and interview on 1/9/13 at 10:15 a.m. revealed: *RN C had washed her hands and put on gloves. *She had gotten those gloves from her pocket. *She had worn those gloves while she had administered medications by gastric tube to resident 12. *She confirmed after she had removed those gloves she had keys, a pen, and a report sheet in her pocket. *She confirmed those items had not been clean and would have contaminated the gloves she had worn for the above observation.</p> <p>Review of the undated glove use policy revealed: *Gloves were to be replaced if they had become</p>	F 441			

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F 441	<p>Continued From page 38</p> <p>contaminated. *It had not addressed where gloves were to be stored before use by the staff.</p> <p>Interview on 1/9/13 at 2:20 p.m. with the director of nursing (DON) confirmed: *Staff were not to have stored gloves in their pockets for use. *That would have contaminated the gloves from other items stored in their pockets. Surveyor: 29162</p> <p>4. Observation on 1/8/13 at 11:25 a.m. of RN D while she had performed a dressing change to resident 4's left heel revealed she had laid the clean treatment supplies directly on the blanket on the resident's bed. Those supplies had included clean gloves, wound measuring tool, tape, gauze, saline wipes, and a bottle of Cavilon cleanser. She then used those supplies that had been laying directly on the resident's blanket to measure the wound and complete the dressing change.</p> <p>Observation on 1/8/13 at 2:15 p.m. of RN D while she had completed a dressing change for resident 2 revealed she laid the clean supplies on the sheet on the resident's bed. Those supplies had included gauze packages, saline wipes, and clean gloves. She then used those supplies that had been laying directly on the resident's sheet to complete the dressing change.</p> <p>Interview with the DON on 1/8/13 at 2:30 p.m. revealed she expected the nurses to use a clean barrier for treatment and dressing supplies. She had stated sometimes they used a chux pad to create a clean barrier.</p>	F 441		
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F 441	Continued From page 39 Review of the provider's Clean Dressing Change, Briggs Corporation, 2006, policy revealed a clean field was to have been created with paper towels or a towelette drape.	F 441		
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, record review, interview, and policy review, the provider failed to ensure the facility was administered in a manner that ensured: *Residents who self-administered medications had self-administration of medication care planned. *All residents were treated with dignity at meal times. *The building was maintained in a sanitary, orderly, and comfortable manner. *Care plans were developed, reviewed, and revised for appropriate problems, goals, and approaches for three of thirteen sampled residents (3, 8, and 17). *One of four residents (16) had a physician's order for the treatment of a pressure ulcer. *One of three residents (8) had documentation to support insertion of a catheter. *One of fourteen residents (4) had an Xray performed in a timely manner.	F 490	F490 1. All residents are at risk. Immediate corrective action was taken as able upon discovery of cited deficiencies as described in this plan of correction. 2. The ED and DNS have reviewed their job descriptions. All residents are kept safe and protected from potential harm. 3. The ED and/or DNS will do walking rounds at least three times weekly as well as complete staff education and audits for deficiencies. Results of corresponding audits will be reported by the ED and discussed at monthly QA&A for further review and recommendations and/or continuation/discontinuation of audits 4. February 7, 2013	2/7/13

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F 490	Continued From page 40 *Necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being in accordance with the comprehensive assessment and plan of care for two of four sampled residents (3 and 8) with pressure ulcers. *There had been necessary care and treatment to prevent a pressure ulcer or the worsening of a pressure ulcer for two of four sampled residents (3 and 8) with a pressure ulcer. *One of one treatment carts remained locked when unattended. *Isolation protocols were put into place for two of two sampled resident's (3 and 6) in droplet isolation. *Provider established policies to prevent the spread of influenza in the Alzheimer's Care Unit (ACU) had been followed. *Five of nine laundry carts were maintained in a cleanable manner. *One of two laundry covers was maintained in a clean manner. *The door to the laundry room was maintained in a cleanable and safe manner. *Clean resident's clothing was delivered in a manner to prevent cross-contamination. *One of one wire towel stand in the bathing room was maintained in a cleanable manner. *Tape had not been used on one of two toilet transfer arms. *Gloves were not stored in staff uniform pockets for use during one of one tubing feeding observation. *One of one resident's (1) dressing change had been completed in a sanitary manner. *Radiology services were provided in a timely manner for one of one resident (4) who required an xray.	F 490		

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F 490	Continued From page 41 *Documentation had been completed for: -One of one sampled resident (6) who required neurological checks after a fall. -One of three sampled resident's (8) who had a catheter. *Through the quality assurance process there had been no re-occurrence of citations from the previous survey. Findings include: 1. All of the above findings are addressed in the following referral deficiencies: F176, F241, F253, F280, F281, F309, F314, F431, F441, F490, F508, F514, and F520.	F 490			
F 508 SS=D	483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review and interview, the provier failed to ensure radiology services were provided in a timely manner for one of one resident (4) who required an xray. Findings include: 1. Review of resident 4's medical record revealed she had experienced a fall on 11/7/12. The resident had experienced pain with movement during a treatment to her left heel. An x-ray of her left knee had been ordered by the physician on 1/8/13. There were no x-ray reports in her medical record that indicated she had received	F 508	F508 1. All residents are at risk. Upon discovery that Resident 4's X-ray was not obtained, the facility investigated and changed its practice on scheduling X-rays. Residents receive their X-rays as ordered. 2. The DNS educated nurses on a change of process for obtaining X-rays on 11/15/2012 (prior to survey) when it was discovered that Resident 4 did not receive an X-ray to her knee. Nurses will be re-educated no later than February 1, 2013 on ordering X-rays. 3. The DNS or designee will audit four charts weekly to ensure X-rays are obtained per order. Audits will be weekly for four weeks and then monthly for three months. Results of corresponding audits will be reported by the DNS and discussed at monthly QA&A for further review and	2/7/13	

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F 508	Continued From page 42 the above ordered x-ray. Interview with the director of nurses on 1/9/13 at 10:45 a.m. revealed the xray ordered for resident 4 had not been done.	F 508	recommendations and/or continuation/discontinuation of audits. 4. February 7, 2013		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, interview, and policy review, revealed the provider failed to ensure complete documentation had been completed for: *One of one sampled resident (6) who required neurological checks after a fall. *One of three sampled resident (8) who had a catheter. *Two of four sampled resident's (3 and 4) who had pressure ulcers. 1. Review of resident 6's record revealed he had a fall on 10/6/12. The interdisciplinary notes	F 514	F514 1. All residents are at risk. No corrective action could be taken for 6. Resident 3 and 4 have documentation that reflects the current care and treatment they are receiving for their pressure ulcers. Resident 8 no longer resides in the facility. 2. The DNS will in-service nurses on ensuring thorough documentation of the resident's condition, including pressure ulcer documentation, neurological checks and justification for catheter use. In-service will be complete no later than February 1, 2013. 3. The DNS or designee will audit four resident charts each week to ensure documentation is complete based on resident's needs and conditions, including neurological checks, catheter justification and pressure ulcer documentation. Audits will continue for four weeks and then monthly for three months. Results of corresponding audits will be reported by the DNS and discussed at monthly QA&A for further review and recommendations and/or continuation/discontinuation of audits.	2/7/13	

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F 514	<p>Continued From page 43</p> <p>stated his neurological checks was with-in normal limits.</p> <p>There was no documentation found of those neurological checks.</p> <p>Interview on 1/9/13 at 9:15 a.m. with the director of nursing (DON) revealed she had not been able to locate the neurological checks documentation. She stated neurological checks should be documented when a resident fell and hit their head.</p> <p>Surveyor: 28057</p> <p>2. Review of resident 8's interdisciplinary notes revealed:</p> <p>*A catheter had been inserted on 10/13/12 after the physician had been called by registered nurse (RN) C.</p> <p>*RN C had documented the resident had asked to go to the bathroom frequently, was not ambulatory, and had been frequently incontinent of bowel and bladder.</p> <p>*The resident had complained of pain once that day and had relief from the pain medication that had been administered.</p> <p>*No other documentation had been entered in support of the use of a catheter.</p> <p>Review of the provider's undated justification for an indwelling catheter revealed urinary retention, contamination of a stage 3 or 4 pressure ulcer, or if the resident was in pain from a mobility impairment during clothing and bedding changes justified an indwelling catheter.</p> <p>Interview on 1/9/13 at 3:10 p.m. with nurses C and D confirmed they had failed to document accurately the resident's pain level with</p>	F 514	4. February 7, 2013		

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F 514	<p>Continued From page 44</p> <p>incontinence products and his inability to use the urinal effectively. They agreed that documentation would have justified the need for a catheter. Surveyor: 29162</p> <p>3. Review of resident 4's medical record revealed a pressure ulcer to her left heel. That pressure ulcer had been 'declared' on 12/28/12 by the DON. There had been conflicting documentation regarding the status of that pressure ulcer. It had been documented as a stage II pressure ulcer on 11/27/12 and 12/4/12. It had been documented as unstageable on 12/28/12, 12/29/12, and 1/1/13. That pressure ulcer had also been referred to as a wound.</p> <p>Refer to F314, finding 2.</p> <p>Surveyor: 32355 Preceptor: 20031</p> <p>4. Random review of resident 3's medical record from 1/7/13 through the morning of 1/8/13 revealed it had not addressed: -The current skin condition to his right heel. -The heel lift boot on his right foot. -Therapys involvement with his pressure ulcer and placement of the heel lift boot. -Repositioning when he had been recently ill with influenza A. -Condition of his skin after his weekly skin assessment completed on 1/6/13 at 8:00 p.m. -His stage II pressure ulcer prior to 1/8/13. -The medical doctor (MD) involvement prior to 1/8/13. -Dietary involvement.</p> <p>Refer to F314, finding 3.</p>	F 514		

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F 514	Continued From page 45 Refer to F280, finding 3.	F 514			
F 520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on record review, interview, and policy guideline review, the provider failed to identify, address, and correct through the quality</p>	F 520	<p>F520</p> <ol style="list-style-type: none"> All residents are at risk. No immediate corrective action could be taken. The IDT team was in-serviced on the QA process by the Director of Clinical Services on January 23, 2013. The Clinical Services Consultant will attend/ review QA meeting minutes monthly for 3 months as well as review all associated audits related to deficient practices cited with this survey. The Clinical Services Consultant will continue to review the QA & A reports on a monthly basis until discontinuance is determined by QA & A and the Clinical Services Consultant. The ED will monitor. February 7, 2013 	2/7/13	

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F 520	<p>Continued From page 46</p> <p>assurance process: *The re-occurrence of citations that had been found in the previous years Center for Medicare/Medicaid services (CMS) survey regarding professional standards, physician visits, infection control, and professional standards for clinical records. *Concerns with 3 of 13 sampled residents' care plans and 3 of 4 sampled pressure ulcers. Findings include:</p> <p>1. Review of the provider's 2011 survey revealed: *The date of the past survey report was 10/19/11. *The provider had been cited for the federal deficiencies F280, F387, F441, and F514. *The plan of correction dates listed for those deficiencies had been 11/16/11. *The above citations plans of corrections had stated audits were to have been performed for four weeks. *Those audit results were to have been reported to the quality assurance committee. *The committee was to have reviewed those results and determined if further review had been needed. *The committee would have determined when the desired corrections had been reached. *The committee would have discontinued the audit process at that point. *Those same deficiencies had been recited with this current 1/7/13 through 1/10/13 survey.</p> <p>Interview on 1/9/12 at 2:05 p.m. with the administrator confirmed: *Past surveys were reviewed for repeat issues and addressed in the QA process. *Pressure ulcers and care plans had not been addressed through the QA process in the past</p>	F 520		
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F 520	Continued From page 47 year. *If two pressure ulcers were to have occurred in one month an action plan would have been developed to address that concern. *That action plan had not been implemented. *Physical therapy, housekeeping, and laundry were not active participants in the QA process. *Those departments had not attended the meetings nor offered audits or reports to the QA committee. Review of the provider's QA and A committee clinical guidelines revealed: *The purpose of the committee was to oversee, monitor, analyze, evaluate, and coordinate the process improvement activities of the facility. *Agenda topics had been identified specific to the needs of the facility. *The agenda calendar was updated on a yearly basis and reviewed monthly by the committee.	F 520			

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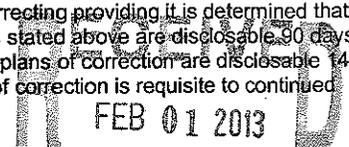
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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/08/13. The Golden LivingCenter-Pierre was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiencies identified at K025, K038, and K044 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.	
K 025 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the one hour fire resistive rating of smoke barrier walls. Unsealed openings around penetrations for communication wires	K 025	K025 1. All residents at risk. The fire barrier wall has been repaired and all other one-hour barrier walls inspected. 2. Staff will be in-serviced by the ED not later than February 1, 2013 on the barrier wall requirements.	2/1/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jawli Dasta</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>2/1/13</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 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 038	<p>Continued From page 2</p> <p>latching hardware classified as double-action because it required one action to unlock the door knob and a second action to turn knob to open door. The double-action hardware could impede opening the doors in an emergency. Interview with the administrator and maintenance director at the time of the exit interview revealed the double-action latching hardware would be replaced as soon as possible with the appropriate single-action hardware.</p> <p>2. Observation and interview at 10:00 a.m. on 1/08/13 revealed the exit door from the ACU, exit gates from the ACU courtyard, and the ACU control doors all had improper signage posted for the keypad code.</p> <p>A. At the exit door from ACU, the code (1-3-5-1-3-5) was printed on paper and stuck upside down above the keypad with sticky tack making it easily removable.</p> <p>B. At the exit gate from the ACU courtyard, the five digit code was printed on paper and laminated and stuck above keypad with sticky tack making it easily removable. The code was disguised by using abnormal print type, was of an improper print size less than one inch, and sideways making it difficult to decipher.</p> <p>C. At the ACU control door, the code was printed on paper and taped vertically to the side of an alcohol based hand rub dispenser which could be easily removed. The buttons on the keypad were worn out and the lettering on the buttons was illegible. A letter key was therefore needed to illustrate the keypad's button layout. This letter key was taped above the keypad and could be</p>	K 038	<p>monthly QA&A for further review and recommendations and/or continuation/discontinuation of audits</p> <p>4. February 7, 2013</p>	

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K 038	Continued From page 3 easily removed.	K 038			
K 044 SS=C	<p>The keypad codes at each location should have been a readily visible on durable signs with letters not less than one inch on contrasting background, and located near the locked exit for availability during emergency situations.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the two-hour fire resistive rated walls. Unsealed penetrations for communication wires into two separate fire barrier walls (in the west wing and between therapy addition and original building) in the corridor were identified. Findings include:</p> <p>1. Observation at 1:50 p.m. revealed the two hour fire barrier wall in the west wing had unsealed openings around penetrations for communication wiring/computer wiring above the lay-in acoustical ceiling above the fire barrier doors in the corridor.</p> <p>2. Observation at 2:30 p.m. revealed the two hour fire barrier wall between the therapy addition and original building had unsealed openings around penetrations for communication wiring/computer wiring above the lay-in acoustical ceiling in the corridor.</p> <p>3. Interview with the maintenance director at the</p>	K 044	<p>K044</p> <p>1. All residents are at risk. The breach in the two-hour fire barrier wall has been repaired. All other barrier walls have been inspected.</p> <p>2. Staff will be in-serviced by the ED not later than February 1, 2013 on the barrier wall requirements.</p> <p>3. The Maintenance Supervisor or designee will inspect fire barrier walls weekly to ensure they are not breached. Audits will continue for four weeks and then monthly for three months. Results of audits will be discussed at monthly QA&A for further review and recommendations and/or continuation/discontinuation of audits</p> <p>4. February 7, 2013</p>	2/7/13	

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K 044	Continued From page 4 time of the observations confirmed those findings.	K 044			

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 000	Initial Comments <i>Addendums noted with an asterisk per 2/7/13 telephone to facility administrator. mp/saouh/JS</i>	S 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.	
S 130	44:04:02:06 FOOD SERVICE Food service must be provided by a licensed facility or food establishment that is inspected by a local, state, or federal agency. The facility must meet the safety and sanitation procedures for food service in chapters 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive, the Food Service Code. In addition, a mechanical dishwasher must be provided in all facilities of 20 beds or more. The facility must have the space, equipment, supplies, and mechanical systems for efficient, safe, and sanitary food preparation if any part of the food service is provided by the facility. This Rule is not met as evidenced by: Surveyor: 20031 Based on observation, testing, interview, and document review, the provider failed to maintain the durability and/or cleanliness in the kitchen of the following: -Kitchen ceiling, -Dishroom walls, -Storage shelves, -Serving board. Findings include:	S 130		

LABORATORY DIRECTOR'S, OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Juli Rasche</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>2/7/13</i>
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S 130	Continued From Page 1 1. Observation on 1/8/13 from 2:45 p.m. to 4:00 p.m. revealed: a. The entire kitchen ceiling had large areas of peeling plaster and chipped paint on it. Those areas ranged in size from basketballs to large beach balls (photos 1 and 4). Interview with the dietary manager (DM) at the time of the observation confirmed those findings. He stated a bid to repair and paint the ceiling had been done in August 2012, but no action had been taken since the bid had been received. Interview with the maintenance manager at 9:30 a.m. on 1/9/13 confirmed the above information given by the DM. He stated there had been no action by the governing board since they had received the first bid. The governing board had thought that bid was too high, but they had not contacted other contractors for an additional bid. b. The spray hose bracket had pulled loose from the wall by the dishwasher (photo 3). The walls behind the dishwasher were discolored, bubbled, and yellowed by constant heat from the dishwasher (photo 2). Interview with the DM at the time of the observation confirmed those findings. He stated he was not aware the spray hose bracket had pulled loose from the wall. He revealed he was aware the wall behind the dishwasher was discolored and had started to bubble from the constant heat from the dishwasher. c. The shelves in the cabinet in the dishroom were dirty with dust and liquid debris. The dust and debris left discolored and dirty areas under the rubber matting (photo 5). Interview with the DM at the time of the observation confirmed that finding. He stated all shelves and drawers were on a regular cleaning schedule. The DM stated that cabinet might have been forgotten, as the items inside that cabinet were seldom used. Review of the kitchen cleaning schedule	S 130	2. The ED will in-service kitchen staff no later than February 1, 2013 on maintaining cleaning schedules, including the underside of the serving board, and reporting any repair needs to the Maintenance Director. 3. The Dietary Manager or designee will audit kitchen cleanliness, including cabinets and the underside of the serving board, weekly for four weeks and then monthly for three months. The Maintenance Director will perform walking rounds in kitchen weekly for four weeks to identify any repair needs. Results of audits will be discussed at monthly QA&A for further review and recommendations and/or continuation/discontinuation of audits 4. February 7, 2013 <i>reported by the dietary manager and MP/5000H/JJ</i>	

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 130	Continued From Page 2 revealed the shelves and drawers were to be cleaned weekly by all kitchen staff. d. The underside of the serving board by the steam table had layers of sticky grime and debris on it that could be scraped free with a fingernail. Interview with the DM at the time of the observation confirmed that finding. He stated he was not aware staff were not cleaning the underside of the serving board. Review of the kitchen cleaning schedule revealed the steam table was to have been cleaned after each meal by all cooks.	S 130		
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed.	S 166	166 1. All residents are at risk. The door codes that were posted by the exit doors have been removed. The space heater has been removed. 2. The ED will in-service staff on the requirement to not have any door codes posted by the exit doors and the requirement that the facility does not use space heaters. Education will be completed no later than February 1, 2013. 3. The Maintenance Director or designee will audit all unattended exits to ensure they are equipped with an electronically audible alarm and that there isn't any code posted and that are no space heaters in use in the facility. Audits will be weekly for <u>four weeks and then monthly for three months</u> . Results of audits will be* discussed at monthly QA&A for further review and recommendations and/or continuation/discontinuation of audits * reported by the maintenance director and 4. February 7, 2013 <i>M P/sooath/JJ</i>	<i>2/7/13</i>

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10663	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PIERRE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET PIERRE, SD 57501		
(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) COMPLETE DATE
S 166	<p>Continued From Page 3</p> <p>The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;</p> <p>(7) Portable space heaters and portable halogen lamps may not be used in a facility;</p> <p>(8) Household-type electric blankets or heating pads may not be used in a facility;</p> <p>(9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and</p> <p>(10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Rule is not met as evidenced by: Surveyor: 18087 A. Based on observation, testing, and interview, the provider failed to maintain the electrically activated audible alarm for unattended doors in an active condition. The exit door in the east wing was alarmed but could be disabled by entering a keypad code that was posted on the side of the keypad near the exit. Findings include:</p> <p>1. Observation and testing beginning at 9:30 a.m. revealed the unattended east door exit was equipped with a door alarm. The door alarm was active at that time. Further observation revealed a keypad was located near that door. Interview with the maintenance director revealed the keypad was used to bypass the door alarm when operating the door. A piece of paper was attached to the side of the keypad that said "312." Testing of the keypad confirmed once the code was typed on the keypad the door could be</p>	S 166		

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10663	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PIERRE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET PIERRE, SD 57501		
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S 166	Continued From Page 4 opened without alarming. Surveyor: 26632 B. Based on observation and interview, the provider failed to follow occupant safety regulations required by the Department of Health. A portable space heater was found in-use in the housekeeping supervisors's office. Findings include: 1. Observation on 1/9/13 at 10:30 a.m. revealed a portable space heater in-use in the housekeeping supervisor's office. Interview with the supervisor at that time confirmed that finding. She stated she had the space heater, because it got cold in her office. Additional observation and interview on that same day at 10:45 a.m. with the maintenance director confirmed the space heater was in-use. He stated staff had been informed space heaters were not allowed in the facility, and he removed the space heater at that time.	S 166		