

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

ORIGINAL

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/20/2013
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NAME OF PROVIDER OR SUPPLIER PIONEER MEMORIAL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 315 NORTH WASHINGTON ST POST OFFICE BOX 368 VIBORG, SD 57070
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/18/13 through 11/20/13. Pioneer Memorial Nursing Home was found not in compliance with the following requirements: F157, F280, F281, F314, and F431.	F 000	Addendums noted with an asterisk per 01/03/14 telephone to facility CEO. DK/SDDOHI/MF	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Thomas V. Ribbe</i>	TITLE CEO	(X6) DATE 12/11/2013
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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 30 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.

DEC 16 2013

If continuation sheet Page 1 of 26

SD DOH L&C

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Preceptor: 32331 Based on interview, record review, and policy review, the provider failed to notify the physician and family of a significant change in a resident's condition for one of three sampled residents (2) with pressure ulcers (an area of skin that breaks down when something keeps rubbing or pressing against it). Findings include: 1. Interview and record review on 11/19/13 at 9:52 a.m. with registered nurse (RN) A regarding resident 2's pressure ulcer care revealed: *The resident had been re-admitted on 11/06/13 from the hospital. *The document labeled Resident Progress Notes dated 11/15/13 and written by RN A regarding the resident's development of a new pressure ulcer stated "Resident has open area to tip of Rt. gt. (right great) toe measuring .9 centimeters (cm) x .8 cm." *No treatment of the new pressure ulcer on the right great (big) toe had been ordered by the physician. *No interventions, monitoring, or outcomes had been documented in the medical record by the nursing staff. *She had stated the physician had "probably not" been notified. *She could not provide documentation the physician had been notified.	F 157	Director of Nursing (DON) along with interdisciplinary team including the Medical Director, Director of Therapy, Director of dietary, Clinical Nurse Educator, and MDS Coordinator reviewed the pressure ulcer prevention and management policy and updated policy to include notification of resident or responsible party, Care-planning, and skin monitoring upon admission and readmission. Directed In-service training was completed on 12/10/2013 with Nursing staff on the policy changes, and on the importance of prompt notification of the Physician, Resident and if known the resident legal representative or interested family member. DON completed an audit of all skin checks for the last month. No other residents were found to have new skin integrity issues with no notification to DON, Physician, or family. DON or designee will monitor skin assessments and CNA'S point of care documentation weekly for one month to ensure any new skin integrity issues/ pressure ulcers are reported and care planned per facility policy. Audit results will be taken to and reviewed at our Performance Improvement council meetings. The Director of Nursing will be responsible for completion of the Plan of Correction and monitoring for continued compliance.	1-9-2014
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* including resident of 12/15/13 MF

* quarterly DK/SD/DH/MF

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F 157	Continued From page 2 Interview and record review on 11/19/13 at 10:41 a.m. with the director of nursing (DON) regarding resident 2's new pressure ulcer on his right great toe revealed: *She had been unaware of the ulcer. *The DON when asked if the physician had been notified stated "We have a policy. We should have called. We did not." *Had the policy been followed the nurse should have filled out an electronic event (computer notification) after finding the new pressure ulcer that should have notified the physician. *She stated the family should have been notified of the resident's new pressure ulcer. Interview on 11/19/13 at 12:00 noon with resident 2's family member revealed she had been unaware the resident had acquired a new pressure ulcer on his right great toe after he had been re-admitted. Review of the provider's 3/22/10 Skin Integrity policy revealed the resident's family should have been notified if a pressure ulcer or change to skin integrity had occurred. The policy had not included notification of the physician. Review of the provider's undated Documentation policy # NH700, page 3, section C stated "Events are required for safety incidents and skin integrity conditions i.e. pressure sores. These events require creating an Event/Occurrence Report." No report had been created for resident 2.	F 157			
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280			

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F 280	<p>Continued From page 3</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to ensure care plans were revised to reflect changes in care and conditions for 5 of 12 sampled residents (1, 3, 5, 6, and 9). Findings include:</p> <p>1. Review of resident 3's medical record revealed: *A sore, swollen area to her right coccyx (tailbone) had been noted on 10/24/13. *The area had been treated with heat and Duoderm (a special dressing) beginning on 10/24/13. *Staff had obtained orders on 11/12/13 for the physical therapist to evaluate the pressure area.</p>	F 280	<p>Care Plan Policy updated to include RN, Social Services, Activities and Dietary will update the Care Plan at the time of notification of change in condition, behavior, diet, or activity preference. MDS Coordination and Interdisciplinary team will review and update resident # 1, 3, 5, 6 and 9 Care Plans to reflect individual plan of care. An audit of all resident's care plans will be completed to assure care plans reflect individual plan of care. DON or Designee will do monthly audits for three months. Audit results will be taken to and reviewed at our Performance Improvement council meetings. The Director of Nursing will be responsible for completion of the Plan of Correction and monitoring for continued compliance.</p>	<p>1-9-2014</p> <p><i>*Quarterly DKISSDDHMF</i></p>

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F 280	<p>Continued From page 4</p> <p>She had given recommendations for: -A wound debrider (a special ointment to remove dead skin from the wound). -The resident to lie down after the breakfast and noon meal to reduce pressure to the area. -Antibiotics if the provider felt the wound was infected. *On 11/13/13 the dietitian made recommendations for increased protein in her diet due to the above pressure area.</p> <p>Review of resident 3's updated 10/17/13 care plan revealed: *She had been at risk of skin breakdown. *It had not been updated to reflect the current pressure area to her coccyx or physical therapy recommendations. *It had not been updated to reflect dietary interventions of Resource (a protein drink) and fortified foods.</p> <p>Interview on 11/20/13 at 10:45 a.m. with the director of nursing (DON) had revealed her expectation would have been for the care plan to have addressed current skin concerns and treatments.</p> <p>Surveyor: 33265 Preceptor: 32332</p> <p>2. Interview on 11/18/13 at 3:10 p.m. with resident 1 revealed that he had on a regular basis been unable to return to sleep after being awakened between 2:00 a.m. and 4:30 a.m. by noises he believed were coming from the next room. Review of his undated care plan revealed that problem was not identified nor addressed.</p> <p>3. Observation on 11/18/13 at 3:30 p.m. of</p>	F 280		

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F 280	<p>Continued From page 5</p> <p>resident 9 revealed she had a bruised area around her right eye.</p> <p>Review of resident 9's record revealed: The resident's care plan had not included her risk of falls or past recent history that had included two falls. *An annual Minimum Data Set (MDS) assessment on 1/5/13 had identified the risk of falls as a care area assessment (CAA) area of concern. *Two incident reports were completed for recent falls: one on 11/12/13 and one on 11/16/13.</p> <p>4. Interview on 11/20/13 at 2:10 p.m. with the MDS coordinator regarding resident 1 and 9's care plans revealed: *She removed care area assessment (CAA) concerns/risks that had been identified during annual or significant change assessments if the concern had not occurred during the three month period before the quarterly review. *She had removed the risk of falls from resident 9's care plan, because there had been no falls during the three months before the last quarterly review. *She agreed the risk might continue even though a fall had not happened in the three months before the quarterly review. *She agreed the care plans needed to be more specific to each resident, and recent changes in resident conditions should have been added to the care plans. *Risk for falls, and history of recent falls should have been noted on care plan for resident 9. *Difficulty in returning to sleep due to noises should have been noted on the care plan for resident 1.</p>	F 280			

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F 280	<p>Continued From page 6</p> <p>Surveyor: 32331</p> <p>5. Review on 11/18/13 of resident 6's complete medical record revealed: *She had been admitted on 10/10/13. *Her diagnoses had included: -Depressive disorder (depression). -Glaucoma (an eye disorder). -Constipation. -A history of hyponatremia (low sodium in the blood). *A physician's order on 10/11/13 for a 1200 cubic centimeter (cc) per day fluid restriction for hyponatremia. *The physician's order as written above had been continued on 11/11/13.</p> <p>Review of resident 6's revised 11/04/13 care plan revealed: *A typed statement to "Offer beverages with calories as fluids are restricted." *It had not contained information regarding the amount of the fluid restriction. *There was no information regarding how the restricted fluid amount was to have been distributed between dietary and nursing departments.</p> <p>Review of resident 6's revised 11/12/13 Resident Roster Flow Sheet used as a pocket care plan for the certified nursing assistants revealed no written information regarding the fluid restriction.</p> <p>Observation and interview on 11/18/13 at 5:45 p.m. in resident 6's room revealed: *She had received eight ounces (oz) apple juice, four oz applesauce, one slice buttered toast, and one banana on a room tray that she had been eating by herself.</p>	F 280			

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F 280	<p>Continued From page 7</p> <p>*A large plastic, blue covered mug with a straw inserted in the top was sitting on the side table.</p> <p>*She was unsure who the mug belonged to.</p> <p>*She stated the mug contained water.</p> <p>*She stated she had been drinking out of the mug.</p> <p>Interview on 11/19/13 at 9:00 a.m. with resident 6's spouse and roommate regarding the resident revealed she had been on a fluid restriction "off and on." He was unsure if she was on a fluid restriction at the above time.</p> <p>Record review on 11/19/13 of resident 6's physician's orders revealed the fluid restriction had been discontinued on 11/18/13.</p> <p>Interview on 11/19/13 at 4:00 p.m. with the director of nursing (DON) regarding physician's orders for residents on fluid restrictions revealed:</p> <p>*There were to have been no water jugs placed in the room for any residents on fluid restrictions.</p> <p>*Fluids were usually provided at meals only.</p> <p>*She stated the amounts of fluid for distribution were to have been written on the care plan.</p> <p>Interview on 11/20/13 at 9:25 a.m. with the consultant registered dietitian and the dietary manager regarding resident 6's fluid restriction revealed the amount and how it was to have been distributed should have been written on the care plan.</p> <p>Interview on 11/20/13 at 1:15 p.m. with the DON revealed there was no written policy on fluid restrictions. She agreed there needed to be a policy for this.</p>	F 280		

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F 280	<p>Continued From page 8</p> <p>Surveyor: 32335</p> <p>6. Observation and interview on 11/18/13 at 3:27 p.m. with resident 5 revealed she had:</p> <ul style="list-style-type: none"> *Contractures (shortening of muscles, ligaments, or tendons that result in loss of joint motion) of the legs, arms, neck, and hands. *A flat call light across her lap. *She had stated she was unable to use the call light. <p>Interview on 11/18/13 at 3:30 p.m. with certified nursing assistant F regarding resident 5 revealed:</p> <ul style="list-style-type: none"> *She could not have used the flat call light due to her contractures. *She called out for help when she needed something. <p>Review of resident 5's 10/3/13 care plan revealed there had been no mention of her not being able to utilize the call light. There was also no mention of how often they had monitored her to make sure her personal care needs had been met.</p> <p>Observation on 11/19/13 at 7:45 a.m. of resident 5 revealed she had been in her wheelchair sitting at the nurses station with a pillow between her legs.</p> <p>Review of resident 5's 10/3/13 care plan revealed there had been no mention of the pillow used between her legs while she was in her wheelchair.</p> <p>Observation on 11/19/13 at 8:05 a.m. and at 11:30 a.m. of resident 5 revealed:</p> <ul style="list-style-type: none"> *She had been in her wheelchair with a pillow between her legs. *She had been taken into the restorative dining room for lunch. 	F 280			

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F 280	<p>Continued From page 9</p> <p>*She had regular cups with straws for her beverages.</p> <p>Interview on 11/19/13 at 11:55 a.m. with restorative care coordinator E regarding resident 5 revealed:</p> <p>*She had not been on a restorative dining program.</p> <p>*She had been eating in the restorative dining room, because she liked the quiet environment.</p> <p>*She had used the regular cups with straws.</p> <p>*All of the above items should have been on her care plan.</p> <p>Review of resident 5's 9/21/13 MDS revealed:</p> <p>*She had required extensive assistance from one staff person to assist her with eating.</p> <p>*She had functional limitations on both sides of her upper and lower extremities (limbs).</p> <p>*The resident's "very important" activity preferences as identified on the MDS had included:</p> <ul style="list-style-type: none"> -Books. -Magazines. -Newspapers. -Listening to music. -Animals. -Keeping up with the news. -Participating in her favorite activities. <p>Review of resident 5's 10/3/13 care plan revealed:</p> <p>*No mention of her eating in the restorative dining room.</p> <p>*She was supposed to have had drinks offered in spout cups (special cups with lids) at meals.</p> <p>*The activities approach stated the following:</p> <ul style="list-style-type: none"> -"Provide 1:1 visitations to room. -Provide manicures per resident's request. 	F 280			

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F 280	<p>Continued From page 10</p> <p>-Invite and escort to activities of choice and provide adaptations as needed (i.e. bingo). -Provide lots of encouragement for resident to attend. -Resident enjoys bingo, musical programs, sports, sitting outdoors (if not too hot), and special events." *No mention of her liking books, magazines, newspapers, animals, or keeping up with the news.</p> <p>Interview on 11/20/13 at 9:00 a.m. with the DON regarding resident 5 revealed: *She could not use the call light and usually called out if she had needed help. *She ate in the restorative dining room, because she liked the quiet environment. *It had been her preference to have the pillow between her legs when she was in her wheelchair. *All the above items should have been on the care plan.</p> <p>Interview on 11/20/13 at 10:55 a.m. with the MDS coordinator regarding resident 5 revealed the information from the MDS regarding her activity preferences should have been care planned.</p> <p>Interview on 11/20/13 at 11:00 a.m. with the dietary manager regarding resident 5 revealed: *She had not known it had been care planned for her to be using spout cups. *She had not known why she would need to use those cups.</p> <p>Review of the provider's 7/24/13 Care Planning Process policy revealed: *The purpose was to ensure a comprehensive, individualized plan of care for each resident.</p>	F 280		

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NAME OF PROVIDER OR SUPPLIER PIONEER MEMORIAL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 315 NORTH WASHINGTON ST POST OFFICE BOX 368 VIBORG, SD 57070		
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F 281	<p>Continued From page 12</p> <p>*Plastic tubing had been attached to the feeding bag.</p> <p>*A bagged plastic syringe dated 11/19/13 had been hanging below the plastic feeding bag on the IV pole.</p> <p>Record review on 11/19/13 of resident 11's complete medical record revealed: *She had been admitted on 10/02/07. *Her diagnoses had included: -Cerebrovascular disease (a disorder of the blood flow to the brain). -Dysphagia (poor swallow). -Gastrostomy (surgical opening into the stomach). -Aphasia (language disorder).</p> <p>Review of resident 11's physician's orders for tube feeding revealed: *On 8/22/13 an order for "8 ounces cranberry juice twice daily. Add one scoop of Beneprotein (instant protein powder) to equal 1 1/2 TBSP [tablespoon] to each cranberry serving to equal 6 grams of protein BID [two times per day]." *On 9/10/07 an order for "1 can ensure plus [a nutritional supplement] daily via g-tube [by tube in stomach]." *On 8/26/13 an order for "Promote with fiber [a high protein, fiber fortified feeding formula and supplement] 1 can plus 225 ml of water flush four times daily."</p> <p>Interview on 11/19/13 at 5:30 p.m. with registered nurse (RN) A regarding resident 11's tube feedings revealed she: *Reported she had mixed the Beneprotein directly with the cranberry juice inside the feeding bag prior to administration to the the resident. *Agreed the water flush orders before and after</p>	F 281	<p>Treatment administration record updated to include flush on all feedings. Beneprotein order changed to be given per manufactures instructions <i>* for resident 11.</i></p> <p>Directed in-service training will be completed on correct transcription on the TAR and the recommended process of administration by the manufacturer. Registered Dietician will review all new tube feeding orders to ensure proper administration of product ordered. Registered Dietician will report to nursing if any discrepencies. DON or designee will observe at random times the mixing and administration of the Beneprotein as well as other feedings for one month to ensure compliance. DON will in-service RN A regarding proper use of the NovoLog FlexPen. Directed in-service training for licensed nurses will be completed on correct use of Novo Log FlexPen. DON or designee will observe random insulin administration for one month to ensure compliance Training and competencies on Insulin administration are completed during orientation and annually by the Clinical Nurse Educator. Audit results will be taken to and reviewed at our PI council <i>* quarterly</i> meetings. The Director of Nursing will be responsible for implementation of the Plan of Correction and continued compliance.</p>	<p><i>DKISSDCH/MF</i></p> <p><i>1-9-2014</i></p> <p><i>DKISSDCH/MF</i></p>	

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F 281	<p>Continued From page 13</p> <p>each tube feeding of the Promote, Ensure plus, and the cranberry juice and Beneprotein were not specific on the physician's orders for administration. *Agreed the orders should have been clarified.</p> <p>Interview on 11/19/13 at the same time and location with RN A with the review of the manufacturer's written instructions on the label of an eight-ounce (oz) container of Beneprotein Instant Protein Powder revealed: *Instructions for a tube feeding: -Add one scoop of powder into two to four ounces of water. -Stir until dissolved. -Administer by syringe through feeding tube. *She agreed the mixing of the Beneprotein for a tube feeding was not being done as outlined above.</p> <p>Interview on 11/19/13 at 9:25 a.m. with the consultant registered dietitian revealed she: *Agreed it had been important to follow the proper procedure for mixing the Beneprotein for tube feeding. *Agreed it could clump together if not mixed properly.</p> <p>Interview on 11/19/13 at 9:36 a.m. with RN B regarding resident 11's tube feedings revealed she: *Reported she had mixed the Beneprotein directly with the cranberry juice. *Reported the Beneprotein and cranberry juice mixture did not mix well and "clumped together" and it had stuck to the side of the feeding bag. *Agreed the only flush ordered with a feeding was the Promote feeding four times per day with 225 ml of water.</p>	F 281		

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F 281	<p>Continued From page 14</p> <p>*Agreed the above flush was not specific on the amount that had been given before and after each feeding.</p> <p>*Agreed there had not been any flush orders with the Ensure plus and the cranberry juice and Beneprotein feedings.</p> <p>*Agreed the flush orders needed to be clarified with the physician.</p> <p>*Agreed the procedures needed to have been more consistent for all nursing staff administering the enteral feedings.</p> <p>Interview on 11/19/13 at 10:53 a.m. with RN C regarding resident 11's tube feedings revealed she:</p> <p>*Had made the cranberry juice and Beneprotein mixture by:</p> <ul style="list-style-type: none"> -Placing one scoop (one and one half tablespoons) of the Beneprotein in a 5 oz plastic cup. -Mixing 60 ml of cranberry juice with the Beneprotein in the plastic cup. -Stirring the above mixture with a plastic spoon until it dissolved. -Placing the the remaining ordered amount of cranberry juice with the above mixture into a syringe. <p>*Agreed the only flush ordered with a feeding was the Promote feeding four times per day with 225 ml of water.</p> <p>*Agreed the above flush was not specific on how much was to have been given before and after each feeding.</p> <p>*Agreed there had not been any flush orders with the Ensure plus and the cranberry juice and Beneprotein feedings.</p> <p>Interview on 11/19/13 at 11:05 a.m. with the director of nursing (DON) regarding resident 11's</p>	F 281		

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F 281	<p>Continued From page 15</p> <p>tube feedings revealed she:</p> <ul style="list-style-type: none"> *Agreed that had been a potential area for errors. *Stated there needed to be a consistent process used by all nurses administering the tube feedings. *Agreed there was a possible concern of clumping with the Beneprotein and cranberry juice in the feeding bag and tubing. *Agreed there needed to be adequate and consistent water flushes for all tube feedings. <p>Review of the provider's undated policy on Managing a Gastrostomy/Jejunostomy (surgical openings into the stomach/small bowel areas through which a tube was placed) revealed the provider needed to have:</p> <ul style="list-style-type: none"> *Confirmed the physician's order for formula frequency, route, and rate of any feedings. *Irrigated with 30 to 60 ml of water before and after each tube feeding. <p>Surveyor: 32332</p> <p>2. Observation on 11/19/13 at 8:20 a.m. of RN A using a NovoLog FlexPen (a disposable dial-a-dose insulin pen) to administer an insulin injection to resident 14 revealed she cleansed her hands. She then dialed the correct dose of 7 units and injected it.</p> <p>RN A had not primed the insulin pen (given a shot of insulin into the air to rid the syringe of any extra air in the chamber) prior to administration of the insulin.</p> <p>Interview on 11/20/13 at 10:20 a.m. with the DON revealed her expectation had been the nurse would have primed the NovoLog FlexPen prior to insulin administration.</p>	F 281		

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F 281	Continued From page 16 Review of the Novo Nordisk NovoLog FlexPen Patient Instruction For Use revised October 2013, http://www.novologpro.com/resources/managing-mealtime.aspx revealed: "Giving the airshot before each injection: Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: *Turn the dose selector to select 2 units. *Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. *Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. *A drop of insulin should appear at the needle tip. If not, change the need and repeat the procedure no more than 6 times."	F 281		
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: 33488 Preceptor: 32331	F 314	Director of Nursing (DON) along with interdisciplinary team including the Medical Director, Director of Therapy, Director of dietary, Clinical Nurse Educator, and MDS Coordinator reviewed the pressure ulcer prevention and management policy and updated policy to include notification of resident or responsible party, Care-planning, and skin monitoring upon admission, readmission and weekly.	1-9-2014

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F 314	Continued From page 17 Based on observation, interview, record review, and policy review, the provider failed to ensure necessary treatment had been completed to prevent the development of a new pressure ulcer for one of three sampled residents (2) with pressure ulcers (an area of skin that breaks down when something keeps rubbing or pressing against it causing a sore). Findings include: 1. Interview on 11/19/13 at 8:15 a.m. with registered nurse (RN) A regarding resident 2 revealed when she had been asked how often he had an assessment done regarding his pressure ulcer care she had replied "We try once a week." Observation, interview, and record review on 11/19/13 from 9:52 a.m. through 10:15 a.m. with RN A regarding resident 2's pressure ulcer care revealed: *He had been wearing a Rooke boot (sheepskin boot used to protect the foot from pressure) on his left foot and a regular shoe on his right foot. *He had treatments ordered for two ulcerated areas: one had been on his left great toe and the other had been behind his left ankle. *RN A had removed a Band-Aid from his left great toe revealing a macerated (the softening and breaking down of skin resulting from prolonged exposure to moisture) area. She had stated, "This is new." *She had applied Betadine (an antiseptic) to his left great toe. *She had re-applied a Band-Aid to his left great toe. -The physician's order had stated the left great toe should have been wrapped daily in gauze. *She had used paper tape to secure the foam dressing behind the left ankle.	F 314	Directed In-service training was completed on December 10 th with Nursing staff on the policy changes, screening for pressure ulcer risk procedure and tool, pressure ulcer care plan development, monitoring and treatment of pressure ulcers policy and procedure, and the care of identified skin concerns and pressure ulcers. DON reviewed all residents with pressure ulcers orders regarding treatment and observed dressings used on separate occasions to ensure nursing is following Physicians orders in regards to pressure ulcer/skin integrity cares. DON met with RN A on 11/19/2013 and reviewed with her individually the pressure ulcer policy and procedure which includes weekly skin assessments, as well as the process for recording completed assessments. RN A completed the event and notified family and physician on 11/19/2013 orders received from primary physician for treatment. DON placed phone call to resident's vascular Dr. for new pressure ulcer treatment on 11/19/2013 orders received and implemented on 11/20/2013. <i>* resident 2 and DK/SDDH/MF</i> <i>* resident 2's DK/SDDH/MF</i> <i>* 2's DK/SDDH/MF</i>		

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F 314	<p>Continued From page 18</p> <p>-The physician's order had stated the foam dressing should have been secured with Kerlix (rolled gauze). *She had completed pressure ulcer care. *When asked why she had not performed her daily pressure ulcer assessment as ordered she stated "I usually do." *Review of the resident's record with RN A revealed: -Staff had initialed the treatment record indicating the assessment had been completed daily. -She had recorded that previously before she had actually performed the assessment. She had stated "I just do it even if I don't always complete it." -She agreed she should not have marked the resident's record if the assessment had not been completed. *When asked why she used a Band-Aid on the left great toe and paper tape behind the ankle instead of following orders she had replied "We change it sometimes." *She stated it had not been her usual practice to change the physician's orders. *She agreed she should have followed physician's orders. *When asked about the new pressure ulcer on resident 2's right great toe, she had stated: -She had not been aware of it. -The note documenting a new ulcer on his right great toe on 11/15/13 had been her signed progress note. -There had not been any assessment, intervention, or monitoring of the new ulcer. -The physician was "probably not" notified of the new ulcer. -Refer to F 157, finding 1.</p> <p>Interview and record review on 11/19/13 at 10:41</p>	F 314	<p>DON instructed staff to remove shoe and place rook boot on rt foot on 11/19/2013. DON will meet with RN A weekly for one month to discuss the findings of each audit. DON or designee will monitor RN A assessments, dressing changes, and documentation weekly for one month, to ensure RN is providing necessary treatment to prevent the development of new pressure ulcers. DON or Designee will do random audits monthly for three months. Audit results will be taken to and reviewed at our PI council <i>*quarterly</i> meetings. MDS coordinator or Designee will review all admission and readmission paperwork for order completion and will complete the Braden Skin assessment per policy. DON will be responsible for implementation of the plan of correction and monitoring for continued compliance.</p>	<i>11/20/13</i>

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F 314	<p>Continued From page 19</p> <p>a.m. with the director of nursing (DON) regarding resident 2's new ulcer on his right great toe revealed:</p> <ul style="list-style-type: none"> *The resident had been re-admitted to the facility from the hospital on 11/06/13 after having had his left leg re-vascularized (surgical correction of absent or diminished blood flow to a limb.) *No ulcer on his right great toe had existed at the time of re-admission. *A new ulcer on his right great toe had been documented by RN A on 11/15/13. *RN A's responsibilities included completing skin/ulcer assessments on all residents in the facility. *An order to check feet and toes daily for sores, and keep pressure off the feet was listed on the treatment plan. -She agreed RN A should have not initialed the treatment record if an assessment had not been done. *An order for "NO SHOES" had been listed on the current treatment plan. *He had been wearing a shoe on his right foot since re-admission from the hospital. *She had been unaware of the physician's order that had stated no shoes for both feet. *She agreed the care plan had not been individualized for the resident regarding his pressure ulcer care. <p>Observation and interview on 11/19/13 at 2:00 p.m. through 2:15 p.m. with the DON regarding resident 2's new ulcer on his right great toe revealed:</p> <ul style="list-style-type: none"> *A Band-Aid had been on his right great toe. *The toe had a stage 2 pressure ulcer (stage described a pressure ulcer where the skin was not intact.) <p>The pressure ulcer had been approximately 1</p>	F 314		

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F 314	<p>Continued From page 20</p> <p>centimeter (cm) in diameter on the tip of his toe. *The toe had been macerated. *She agreed the Band-Aid had caused the maceration since it had not been changed. *She agreed there had been no interventions, monitoring, or outcomes documented or completed by staff regarding that new pressure ulcer.</p> <p>Interview and record review on 11/19/13 at 4:00 p.m. with the DON regarding resident 2's new pressure ulcer revealed: *There had been an order written on 11/6/13 for Rooke boots to have been placed on both feet. *After she had reviewed the above order she had stated "We caused this ulcer." *She had agreed the new pressure ulcer on the tip of his right great toe had been caused by: -Nursing staff not following physician's orders by applying a Rooke boot to the right foot. -RN A not reporting the new right great toe ulcer to the physician once it had been found. -Nursing staff not providing interventions for the above mentioned ulcer.</p> <p>Review of the provider's 3/22/10 Skin Integrity policy revealed it had not included notification of the physician.</p> <p>Review of the provider's undated Documentation policy # NH700, page 3, section C stated "Events are required for safety incidents and skin integrity conditions i.e. pressure sores. These events require creating an Event/Occurrence Report." No report had been created for resident 2.</p>	F 314		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	<p>Continued From page 21</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to ensure:</p>	F 431			

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F 431	<p>Continued From page 22</p> <p>*Accountability was maintained for schedule IV (four) (government controlled and highly diverted [stolen]) medications for 2 of 15 random and sampled residents (4 and 15).</p> <p>*Schedule II narcotics had been secured with double locks in 1 of 1 medication rooms. Findings include:</p> <p>1. Interview on 11/19/13 at 4:15 p.m. with the nurse educator revealed the provider's pharmacy:</p> <p>*Removed all as-needed (PRN) medication cassettes (plastic reusable medication storage containers) including schedule III and IV medications weekly on Thursday along with the routine medication change-over.</p> <p>*The pharmacist then refilled the empty slots in the used cassettes with medication and returned the replenished supply to the provider the next week with the medication change-over.</p> <p>At the above date and time, the nurse educator revealed:</p> <p>*She performed a random audit of schedule III and IV medications on Friday after the medication change-over.</p> <p>*The audits had not included all PRN schedule III and IV medication. Only a few of the cassettes had been audited weekly.</p> <p>*She audited the use of the PRN medication cassettes to the last medication change-over date with the PRN medication notes and the medication administration record (MAR).</p> <p>*The audit would have shown if there had been missing medication not accounted for.</p> <p>2. Observation on 11/20/13 at 10:20 a.m. of schedule III and IV medications in the treatment cart and medication cart revealed the following for residents 15 and 16:</p>	F 431	<p>DON, Clinical Nurse Educator and Pharmacist met regarding the PRN return and the schedule III and IV medication audit on 12/3/2013. The medication policy was updated to include the new process. All schedule III and IV PRN medications were logged with the current count on 12/3/2013.</p> <p>Nursing staff will not send prn medication back with medication exchange and will log any newly ordered PRN cassettes upon arrival. Clinical Nurse Educator or designee will do weekly audits for one month. Nursing staff educated on new procedure on 12/3/2013 and Directed Inservice training was completed 12/10/2013. The provider's emergency medication supply and all schedule II medications that have been designated to be destroyed had a lock placed on each container. A locked medication box was installed for all scheduled and prn scheduled II medications to ensure all medication are secured by a double lock. DON or designee will complete weekly audits of the medication cabinet to ensure all medications are secured per policy. Audit results will be taken to and reviewed at our PI council *quarterly meetings. The Director of Nursing will be responsible for implementation of the Plan of Correction and continued compliance.</p>	1-9-2014	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2013
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F 431	<p>Continued From page 23</p> <p>a. Resident 15 had a PRN medication cassette containing lorazepam 0.5 milligrams (mg) in the treatment cart that revealed: *The cassette contained eight slots. *Six covered slots contained one tablet each. *Two slots were empty.</p> <p>Review of resident 15's November 2013 MAR revealed: *She had not used lorazepam in November 2013. *She had used lorazepam on the following dates: -10/29/13 at 9:50 p.m. -10/8/13 at 2:45 a.m. *The most recent medication change-over had been November 14, 2013. *Two tablets had not been accounted for.</p> <p>b. Resident 4 had a PRN medication cassette containing lorazepam 1 mg in the treatment cart that revealed: *The cassette contained eight slots. *Four covered slots contained one tablet each. *Four slots were empty.</p> <p>Review of resident 4's November 2013 MAR revealed: *She had used lorazepam on the following dates: -11/20/13 at 7:30 a.m. -11/17/13 at 7:30 a.m. -11/16/13 at 7:30 a.m. -11/11/13 at 7:00 a.m. *The most recent medication change-over had been November 14, 2013. *One tablet had not been accounted for.</p> <p>3. Observation on 11/20/13 during review of the medication room revealed: *This surveyor opened an unlocked cupboard that</p>	F 431			

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F 431	<p>Continued From page 24</p> <p>contained:</p> <ul style="list-style-type: none"> -The provider's emergency medication supply. -All medication that had been designated to have been destroyed during the pharmacist's next visit. -Storage for all schedule II medications. <p>Interview at that time with registered nurse (RN) B revealed she had not known why the cupboard had been unlocked. She stated one of the cupboard doors required the nurse to manually secure a hook and eye lock before using a key to secure the door. She stated sometimes the hook did not get secured. When that happened the key would not secure the cupboard, and both doors would swing open.</p> <p>Interview on 11/20/13 at 10:20 a.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> *The schedule III and IV medication audits had been flawed. *The pharmacist was supposed to send out a full cassette of medication with each medication change-over, but it had not always occurred. *The narcotic cupboard had not had been securely locked. <p>Interview on 11/21/13 at 12:30 p.m. with the provider's pharmacist revealed:</p> <ul style="list-style-type: none"> *The schedule III and IV medication cassettes had been returned back to the pharmacy weekly for billing purposes. *She stated the system (to have those medications leaving and re-entering the building) had not been the best practice for their security. *She stated she would have preferred the cassettes remained in the facility. <p>Review of the provider's revised February 2013 Medication Management policy revealed:</p>	F 431		

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F 431	<p>Continued From page 25</p> <p>**It is the responsibility of the Charge Nurse to ensure the security of the medication room and the medication and treatment carts.**</p> <p>**It is the responsibility of the Charge Nurse to ensure that medication variances are reported, as needed (PRN) medication administered and response is documented, and medications administered have a written order by a practitioner.**</p> <p>**A double lock system is used for storing narcotics (schedule II drugs).**</p> <p>Review of Patricia A. Potter and Ann Griffin Perry, Fundamentals of Nursing, 6th Edition, Mosby, St. Louis, Mo, 2005, revealed:</p> <p>*Page 907:</p> <p>- "All controlled substances are handled according to strict procedures that account for each medication."</p> <p>- "Medications should be charted immediately after administration."</p> <p>*Page 828:</p> <p>- "Discrepancies in narcotic counts are reported immediately."</p> <p>- "A special inventory record is used each time a narcotic is dispensed and provides an accurate ongoing count of narcotics used and remaining."</p>	F 431		

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NAME OF PROVIDER OR SUPPLIER PIONEER MEMORIAL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 315 NORTH WASHINGTON ST POST OFFICE BOX 368 VIBORG, SD 57070
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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/19/12. Pioneer Memorial Nursing Home was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 11/19/13 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain a one hour fire resistive path of egress from the basement to the	K 033	Original Construction	F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Thomas R. Ribter, CAO</i>	TITLE	(X6) DATE 12/11/2013
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 45 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEC 16 2013

SD DOH L&C

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K 033	Continued From page 1 exterior of the building. Two basement stairways discharged onto the main level corridor system. Findings include: 1. Observation at 10:45 a.m. on 11/19/13 revealed a basement stairway discharged into the main level adjacent to the elevator. Further observation at 11:00 a.m. revealed a basement stairway from the boiler room discharged onto the main level in the arboretum. Review of the previous survey report confirmed those conditions were part of the original construction.	K 033		
K 040 SS=C	The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000. NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain clear door widths of at least 32 inches for one randomly observed exit access door (boiler room). Findings include: 1. Observation at 11:30 a.m. on 11/19/13 revealed the exit access door from the boiler room into the arboretum was only 24 inches wide and did not provide a clear opening width of 32 inches. Review of the previous survey report confirmed that condition was part of the original	K 040	Original Construction	F

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K 040	Continued From page 2 construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 040			

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10698	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/20/2013
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S 000	Initial Comments Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 11/18/13 through 11/20/13. Pioneer Memorial Nursing Home was found not in compliance with the following requirement: S253.	S 000		
S 253	44:04:04:11.01 SECURED UNITS Each facility with secured units must comply with the following provisions: (1) A physician's orders for confinement that includes medical symptoms that warrant seclusion or placement must be documented in the...resident's chart and must be reviewed periodically by the physician; (2) Therapeutic programming must be provided and must be documented in the overall plan of care; (3) Confinement may not be used as a punishment or for the convenience of the staff; (4) Confinement and its necessity must be based on a comprehensive assessment of the...resident's physical and cognitive and psychosocial needs, and the risks and benefits of this confinement must be communicated to the...resident's family; (5) Locked doors must conform to Sections 18.2.2.2.4 and 19.2.2.2.4 of NFPA 101 Life Safety Code, 2000 edition; and (6) Staff assigned to the secured unit must have specific training regarding the unique needs of...residents in that unit. At least one caregiver must be on duty on the secured nursing unit at all times.	S 253		

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

TITLE

Thomas R. Rahl, CEO

STATE FORM

02/199

9MNY11

<p>RECEIVED</p> <p>12/11/2013</p> <p>If continuation sheet</p> <p>DEC 16 2013</p> <p>SD DOH L&C</p>	(X6) DATE

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S 253	<p>Continued From Page 1</p> <p>This Rule is not met as evidenced by: Surveyor: 32335 Based on observation, interview, and policy review, the provider failed to ensure there was a therapeutic (producing good effects on your body or mind) activity program for one of one memory support unit (Haven). Findings include:</p> <p>1. Observation on 11/18/13 from 2:55 p.m. through 3:25 p.m. revealed the television had been on in the living room. There had been no activities going on at that time. There had been four residents in that area during that time.</p> <p>Interview on 11/18/13 at 3:20 p.m. with certified nursing assistant (CNA) G revealed Haven had been staffed with one staff member during all shifts. Eight residents lived in Haven.</p> <p>Observation on 11/18/13 from 5:45 p.m. through 6:00 p.m. revealed the television had been on in the living room. CNA G had been assisting residents get ready for bed. There had been no activities going on during that time.</p> <p>Observation on 11/19/13 at 7:55 a.m. revealed two male residents were sitting at the breakfast table.</p> <p>Observation on 11/19/13 from 9:30 a.m. through 9:45 a.m. revealed: *The television had been on in the living room. *The same two male residents mentioned above had been sitting at the same table sleeping. *Two female residents had been wandering and looking out the windows. *At 9:45 a.m. activities assistant H had entered the unit.</p> <p>Interview on 11/19/13 at 10:20 a.m. with activities assistant H revealed she had just completed</p>	S 253	<p>The Director of Activities or Designee will set up a therapeutic program for each resident based on their Medical Data Set (MDS) Activity Assessment and current physical and mental capabilities as observed during engagement in activities of past interest or current likes and hobbies. In addition to care planning, individual resident lists along with activity kits will be available for staff to utilize to ensure activities of choice are being offered to each resident. A joint staff meeting between Activities and Direct Care staff will be held to educate, plan, and implement a team approach to ensure all residents receive Therapeutic activities based on their needs, preferences and cognitive level. Upon admission, each resident will have an individualized therapeutic program established by using their Admission MDS Activity Assessment. Each individual's therapeutic program will be reviewed and updated with significant change in condition or a minimum of quarterly. Director of Activities or Designee will monitor the therapeutic program for one month after implementation to ensure proper implementation and report results through the Performance Improvement committee. The Director of Activities will be responsible for implementation of the Plan of Correction and ongoing compliance.</p>	1-9-2014

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S 253	Continued From Page 2 devotions and reading to the residents. Interview on 11/19/13 at 12:05 p.m. with CNA I regarding activities in the unit revealed: *She had been charting. *She had worked at the nursing home for thirteen years. *She had worked most of those years in Haven. *She had not done activities with the residents. *She had done a lot of talking with the residents. *There were books available for the residents to read. *The activities department had been responsible for the activities in Haven. *The Haven activity time had been 10:00 a.m. through 10:30 a.m. and 4:00 p.m. through 4:30 p.m. each day. *She had not known what activities had been done with the residents. Observation on 11/19/13 from 1:50 p.m. through 2:00 p.m. revealed no activities had been going on in the unit. Interview on 11/20/13 at 8:00 a.m. with the director of nursing (DON) regarding activities in the unit revealed: *The night before she had spoken to the activities director who had been out on medical leave. *The activities director had stated Haven activities mirror the activities from the nursing home. Interview on 11/20/13 at 9:00 a.m. with activities assistant J regarding the activities in the unit revealed: *The activities department had been responsible for the activities in the unit. *The activities schedule had been 10:00 a.m. through 10:30 a.m. and 4:00 p.m. through 4:30	S 253		

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S 253	<p>Continued From Page 3</p> <p>p.m.</p> <p>*Activities done in the morning had included devotions, reading devotion books, or reading Chicken Soup for the Soul books.</p> <p>*Activities done in the afternoon had included reading, games, or puzzles.</p> <p>*She had not been aware of the need for a therapeutic program in the unit.</p> <p>Interview on 11/20/13 at 2:30 p.m. with the DON regarding activities in the unit revealed:</p> <p>*She had not been aware of the need for a therapeutic program in the unit.</p> <p>*She was unaware the activities policy had included therapeutic programming for the Alzheimer's/Dementia unit (Haven).</p> <p>Review of the provider's June 1993 Activity Program policy revealed:</p> <p>*The purpose had been to provide a therapeutic activity program which would have maximized remaining functions, enhanced the quality of life, and validated each individual resident.</p> <p>*Residents of the Alzheimer's/Dementia unit would be provided with specialized dementia programming which would be integrated into their structured daily routine.</p>	S 253		