

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

ORIGINAL

PRINTED: 08/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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NAME OF PROVIDER OR SUPPLIER ABERDEEN HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401
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F 000	INITIAL COMMENTS Surveyor: 12218 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/22/14 through 7/24/14. Aberdeen Health and Rehab was found not in compliance with the following requirements: F176, F202, F221, F278, F280, F281, F309, F323, F332, F386, F431, F441, and F514.	F 000		
F 176 SS=E	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE 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. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to ensure two of two sampled residents (24 and 25) who self-administered a medication had been assessed for their capability to self-administer medications. Findings include: 1. Observation on 7/22/14 at 11:20 a.m. of registered nurse (RN) A during a medication administration of a nebulizer (machine that turns liquid medication into a mist for inhaling into the lungs) treatment revealed the nurse had: *Placed the medication into the nebulizer chamber. *Placed the inhalation device into resident 24's hand and started the nebulizer machine.	F 176	See next page	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Megan Klems TITLE: Exe Director (X6) DATE: 8-18-14

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 75 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.

Stamp: AUG 29 2014 Facility ID: 0065 SD DOH L&C

Stamp: AUG 20 2014 If continuation sheet Page 1 of 42 SD DOH L&C

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F 176	<p>Continued From page 1</p> <p>*Left the resident's room for several minutes.</p> <p>When RN A returned to the resident's room approximately fifteen minutes later resident 24 had already turned the machine off and placed the device on the bedside table.</p> <p>2. Observation on 7/22/14 at 11:30 a.m. of RN A during medication administration of a nebulizer treatment with resident 25 revealed she:</p> <p>*Placed the medication into the nebulizer chamber.</p> <p>*Placed the inhalation mask on resident's face and started the machine.</p> <p>*Left the resident's room for several minutes.</p> <p>Interview with RN A at that time revealed:</p> <p>*She had not stayed with the residents during the nebulizer administrations.</p> <p>*She returned during the nebulizer treatments to check on the residents to see if they were receiving the medication.</p> <p>*Resident 25 had removed his mask at times in the past.</p> <p>*If she could hear resident 25 singing, there was "a good chance he did not have his mask on."</p> <p>3. Review of resident 24 and 25's medical records revealed:</p> <p>*There had not been a physician's order for medication self-administration in either record.</p> <p>*Resident 25's care plan had indicated he had Alzheimer's disease with confusion and forgetfulness.</p> <p>*The care plans had not indicated the residents were capable of self-administering medications.</p> <p>Interview on 7/24/14 at 8:55 a.m. with the director of nursing revealed it was not her expectation the</p>	F 176	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states with respect to:</p> <ol style="list-style-type: none"> Residents' #24 has been discharged from the facility. Resident #25's care plan has been updated to reflect his current medication needs. Residents that are cognitively appropriate for self administering medications are reviewed for self assessment for medications upon admission, quarterly and with any change in condition. <i>9-12-14 MK</i> By August 28th, 2014 <i>8-20-14</i> the MDS Coordinators' will be educated on the self administration of medication assessment and assessment guidelines. The DNS and/or her designee will audit two residents' per week for one month then one residents per week for two months for assessment of self administration of medications. <p><i>By Corporate Clinical Reimbursement RN</i></p>		

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F 176	Continued From page 2 nurse should have remained in the resident's room during the medication administration. Review of the provider's September 2009 Assessment for Self-Administration Guidelines revealed: *The self-administration assessment would have been used if the resident wished to administer their medications or some of their medications such as inhalers. *The interdisciplinary team would have analyzed the self-administration assessment data to decide if the resident had been safe to administer their own medication. *The resident should have been reassessed quarterly or more often to assure they were safe to administer their own medication. Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013, page 565, revealed: "In all settings, nurses are responsible for evaluating the effects of medications on the patient's ongoing health status, teaching them about their medications, and side effects, ensuring adherence to the medication regimen, and evaluating the patient's and family caregiver's ability to self-administer medications."	F 176	5. The DNS and/or her designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring. 6. The DNS is responsible for this area of compliance.	09/12/2014	
F 202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i)	F 202	<i>See next page</i>		

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F 202	<p>Continued From page 3 or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on record review, interview, and policy review, the provider failed to complete the transfer/discharge form, resident valuables inventory sheet, and the medication return/destruction document prior to discharge for one of three transferred or discharged sampled residents (17). Findings include: 1. Review of the complete medical record of resident 17 revealed: *Resident 17 was transferred to the hospital on 4/9/14. *The transfer/discharge sheet had several blank areas. These areas were: -Chief complaint (reason the person went to the hospital). -Relevant information on behavior, ambulation (ability to walk), bladder, bowel, feeding and usual level of functioning. *The resident had left belongings at the providers. However she had not returned to the provider. She had been transferred to another facility on 4/11/14. *There had been no documentation on where the medications had gone after the resident transferred to another facility upon leaving the hospital.</p> <p>Interview on 7/24/14 at 9:40 a.m. with the director of nursing revealed she agreed: *The transfer/discharge sheet had not had all the information documented.</p>	F 202	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states with respect to:</p> <ol style="list-style-type: none"> 1. Resident #17 has been discharged from the facility. 2. All residents that are transferred or discharged from the facility will have a copy of the transfer or discharge paperwork in their discharged record. All residents have an inventory list in their record. This will be signed upon discharged to ensure all valuables were sent with the resident. All medications that are sent with a resident are documented and those left in the building are sent back to the pharmacy or destroyed. The required paperwork is completed depending upon what happens to the medication. 3. By September 12th, 2014 all nursing and social services staff will be educated the discharge/transfer forms and inventory list. Nursing staff will be educated on the discharge/transfer of medications once a resident leaves the facility <i>by RN educator.</i> 	

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F 202	Continued From page 4 *There was no record of what happened to the medications after the resident had left the facility. Review of the provider's 1/1/13 Disposal/Destruction of Expired or Discontinued Medications procedure revealed: *Provider should have disposed of medications left in the facility after the resident had been discharged in a timely fashion, no more than 90 days after the date the medication was discontinued. *A copy of the Product Destruction page (identifies what medications were destroyed after discharge) should have been retained in the resident's medical record.	F 202	4. The DNS and/or her designee will audit the discharge paperwork including medications for the next 5 discharges and then two discharges per month for the next 2 months. 5. The DNS and/or her designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring. 6. The DNS is responsible for this area of compliance.	9/12/2014
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to assess the need for a seatbelt restraint for one of one sampled resident (12) who used a seatbelt in her wheelchair and who could not release the seatbelt upon request. Findings include: 1. Observation and interview on 7/24/14 at 7:20 a.m. with medical records staff H regarding resident 12 revealed the resident had a seatbelt around her waist while she sat in her wheelchair.	F 221	<i>See next page</i>	

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F 221	<p>Continued From page 5</p> <p>Upon request at that time by medical records staff H the resident had not been able to release the seatbelt. She had been non-verbal and had not spoken.</p> <p>Review of resident 12's 10/20/13 and 6/28/14 Minimum Data Set (MDS) assessments revealed: *She had short and long term memory problems. *Her daily decision making skills were "moderately impaired - decisions poor; cues/supervision required." *She had not been assessed as having a restraint.</p> <p>Review of resident 12's 7/1/14 care plan revealed she had "a communication problem r/t [related to] cognitive [memory] decline." There had been no mention of the seatbelt on the care plan.</p> <p>Review of resident 12's medical record revealed: *She had a diagnosis of dementia (impairment of memory). *A physician's order signed on 6/5/14 stated "self release seat belt when in w/c [wheelchair]." *The physician's order had not mentioned the medical diagnosis, the reason for the use, when it should have been used, when it should have been checked, and when it should have been released. *There had been no quarterly assessments completed for the use of the seatbelt.</p> <p>Interview and policy review on 7/24/14 at 8:10 a.m. and at 9:15 a.m. with MDS coordinator E regarding resident 12 revealed quarterly assessments for the use of the seatbelt had not been done. The seatbelt should have been assessed as a restraint as she could not release the belt herself. The care plan should have been</p>	F 221	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states with respect to:</p> <ol style="list-style-type: none"> 1. Resident #12's care plan has been updated to reflect the seatbelt in use. A new assessment has been completed, physician's orders updated and consent has been obtained from the residents' family. 2. By August 26, 2014 ⁹⁻¹²⁻¹⁴ the MDS Coordinators' will be educated on the functional review assessment and assessment guidelines. 3. All residents are assessed upon admission, quarterly and with any change in condition for their functional status and restraint use. <p><i>By Corporate Clinical reimbursement RW. MK 8-26-14</i></p>	

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F 221	Continued From page 6 updated to reflect the use of the seatbelt. Review of the provider's March 2008 Restraints Assessment Policy revealed: **"Prior to a restraint being applied, a physical restraint assessment will be performed." *Documentation of alternatives to restraints should have been included on the assessment. *A physician's order should have been obtained that included "medical diagnosis, type, reason for use, when to be used, check every 30 minutes, and release every two hours with position change." *The care plan should have been updated to reflect the use of the seat belt. **"Review restraint use quarterly by following the physical restraint reduction policy."	F 221	4. The DNS and/or her designee will audit 2 residents monthly for proper restraint use and update assessment and care plan when necessary. 5. The DNS and/or her designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring. 6. The DNS is responsible for this area of compliance.	9/12/2014
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who wilfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278	<i>See next page</i>	

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F 278	<p>Continued From page 7</p> <p>\$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to: *Ensure the Brief Interview for Mental Status (BIMS) and the resident mood interview were completed based on the residents level of comprehension for 2 of 15 sampled residents (11 and 12). *Accurately assess: -Falls with no injury for 1 of 15 sampled residents (11). -The use of a seatbelt restraint for one of one sampled resident (12) with a seatbelt. Findings include:</p> <p>1. Review of resident 11's 5/24/14 Minimum Data Set (MDS) assessment revealed: *He was able to make himself understood. *He usually was able to understand others. *The BIMS and the resident mood interview had not been completed with the resident. *Staff had answered questions for both interviews.</p> <p>Review of resident 12's 6/28/14 MDS assessment revealed:</p>	F 278	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states with respect to:</p> <ol style="list-style-type: none"> 1. Resident #11 and #12's MDS's have been corrected. 2. The MDS section B is to be completed with each resident prior to obtaining staff interviews. 3. By September 12th, 2014 the MDS Coordinators' will be educated on section B and when to complete per the regulation and RAI guidelines. 4. The DNS and/or her designee will audit 4 MDSs per month for 2 months to confirm that resident interviews are being completed based on the responses to Section B. 5. The DNS and/or her designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring. 6. The DNS is responsible for this area of compliance. <p><i>ML 8/26/14</i></p> <p><i>My Corporate Clinical Reimbursement</i></p>	9/12/2014
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F 278	<p>Continued From page 8</p> <ul style="list-style-type: none"> *She was sometimes able to make herself understood. *She was sometimes able to understand others. *The BIMS and the resident mood interview had not been completed with the resident. *Staff had answered questions for both interviews. <p>Review of the October 2013 Long-Term Care Facility Resident Assessment Instrument User's Manual revealed the BIMS and the resident mood interview should have been conducted with the resident unless the resident was rarely or never understood.</p> <p>2. Review of resident 11's 5/24/14 MDS assessment revealed he had one fall with no injury since the prior assessment done on 3/10/14.</p> <p>Interview on 7/22/14 at 4:15 p.m. with the director of nursing revealed resident 11 had not had any falls since the prior assessment on 3/10/14. It had been entered wrong on the 5/24/14 MDS.</p> <p>Interview on 7/23/14 at 4:25 p.m. with MDS coordinator E regarding resident 11's 5/24/14 MDS revealed she had entered the wrong information. He had not had any falls since the prior MDS on 3/10/14.</p> <p>3. Review of resident 12's 6/28/14 MDS assessment revealed no physical restraints were currently being used.</p> <p>Observation and interview on 7/24/14 at 7:20 a.m. with medical records staff H regarding resident 12 revealed the resident had a seatbelt around her waist while she sat in her wheelchair.</p>	F 278		
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F 278	Continued From page 9 Upon request at that time by medical records staff H resident 12 had not been able to release the seatbelt. She had been non-verbal and had not spoken.	F 278			
F 280 SS=E	Interview and policy review on 7/24/14 at 8:10 a.m. and at 9:15 a.m. with MDS coordinator E regarding resident 12 revealed the seatbelt should have been entered as a restraint on the MDS since she could not release the belt herself. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 32335	F 280	See next page		

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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 280	<p>Continued From page 10</p> <p>Based on observation, record review, interview, and provider's guideline review, the provider failed to update and revise care plans for 3 of 15 sampled residents (6, 11, and 12) for the residents current conditions. Findings include:</p> <p>1. Observation on 7/24/14 at 7:20 a.m. of resident 12 revealed she had a seatbelt around her waist while she sat in her wheelchair.</p> <p>Review of resident 12's 7/1/14 care plan revealed there had been no mention of the seatbelt on the care plan. The care plan stated she had been "transferred to BWC [Birchwood court] on 1/30/13." The care plan had not been updated to reflect she had moved out of Birchwood Court in May 2014.</p> <p>Interview and on 7/24/14 at 9:30 a.m. with the director of nursing (DON) regarding resident 12 revealed the care plan should have been updated to reflect the use of the seatbelt and that she no longer resided in Birchwood Court.</p> <p>2. Observation on 7/22/14 at 12:15 p.m. and at 5:30 p.m. of resident 11 revealed he needed assistance with eating. Staff had to pick up the utensil and feed him.</p> <p>Review of resident 11's 5/29/14 care plan revealed he had a focus area related to an unplanned weight loss. The interventions stated he ate independently.</p> <p>Interview on 7/23/14 at 8:15 a.m. with the dietary manager revealed she had not updated the care plan to reflect he needed assistance with eating.</p>	F 280	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states with respect to:</p> <ol style="list-style-type: none"> 1. Resident #8, #11, #12's care plans have been updated. 2. All residents' care plans have been reviewed and interventions updated regarding weight loss, restraints and falls. 3. By September 12th, 2014 MDS Coordinators will receive education per guideline maintaining updated care plans <i>by for audit compliance</i> 4. The DNS and/or her designee will audit 2 Care Plans per week to confirm current care plan is in the chart and updated. 5. The DNS and/or her designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring. 6. The DNS is responsible for this area of compliance. <p><i>nee p. 26-14</i></p>	9/12/14
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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: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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NAME OF PROVIDER OR SUPPLIER ABERDEEN HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401
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F 280	<p>Continued From page 11 Surveyor: 12218 3. Review of resident 6's medical record revealed: *She was a fall risk and had several falls in the past. *Her recent falls had been on 7/6/14 and on 7/18/14. *Diagnoses included: dementia (memory problem), hypertension, anxiety, depressive disorder, coronary artery disease. *Her medications included an antipsychotic [medication used for mental problems (Abilify)], an antianxiety (Ativan), and an antidepressant (Zoloft).</p> <p>Review of resident 6's 5/14/14 care plan revealed: *Focus areas for falls stated: "actual fall related to unsteady gait, and attempting to self transfer." -Revision date was 5/1/14. -No recent falls were identified since the care plan revision. *Interventions: -Assist with all transfers. -Make sure has appropriate footwear when transferring. -Try to redirect when resident trying to self transfer.</p> <p>Interview with the Minimum Data Set coordinator E at 1:30 p.m. on 7/23/14 regarding resident 6's falls revealed: *She was aware of the past falls. *She did not generally update the care plan on falls. *Revisions were done at the care conference following the completion of the MDS. *She was tracking and trending falls, but that was on another report.</p>	F 280		
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F 280	<p>Continued From page 12</p> <p>*She confirmed the care plan had not been updated under the identified fall risk with the recent occurrences and any additional interventions.</p> <p>*She stated the falls were on-going.</p> <p>Review of the provider's September 2011 Care Plan Guidelines revealed:</p> <p>*All care plans should have included individual and/or combined focus problems that addressed the following areas:</p> <ul style="list-style-type: none"> -All current acute and chronic conditions for which they were receiving medication, treatment and/or care. -Discharge plans. -Medication therapy, treatments, laboratory tests, and monitoring. -Any outside consultations such as physical therapy. -Any restraints, alarms, and assistive or adaptive equipment. such as wheelchairs and mechanical lifts. -Any special nutritional supplements. -Types of assistance that were required for all activities of daily living. -Any mood/behaviors, activities that would provide a diversion (new focus) and how staff should have intervened. -Anything that would have been specific for that resident such as what the staff would have needed to know to provide care to the resident. 	F 280		
F 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p>	F 281	See next page	

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F 281	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488</p> <p>Based on observation, interview, record review, and policy review, the provider failed to:</p> <ul style="list-style-type: none"> *Check placement for a gastrostomy (g-tube) [feeding tube inserted into the stomach] prior to administering medications through the tube for one of one sampled resident (19) during two of two observed medication administrations. *Update physician's orders when changes in residents had occurred for two of fifteen sampled residents (3 and 10). *Complete and monitor bowel records in one of one secured memory support unit (Birchwood). Findings include: <p>1. Observation on 7/22/14 at 10:28 a.m., and observation and interview again on 7/23/14 at 10:30 a.m. with registered nurse (RN) J when she had administered medication through resident 19's G-tube revealed:</p> <ul style="list-style-type: none"> *She had not checked tube placement prior to administering medications. *She was aware tube placement should have been checked prior to administering the medications to ensure the safety of the resident. <p>Interview occurred on 7/23/14 at 10:45 a.m. with the DON regarding the above medication administrations. She revealed it had been her expectation G-tube placement should be performed prior to administering medications.</p> <p>Review of the July 2014 Gastrostomy Tube Feeding Guidelines policy revealed tube placement was to have been checked prior to administering medications or feedings.</p>	F 281	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states with respect to:</p> <ol style="list-style-type: none"> 1. Resident #19, #3 and #10's care plans have been updated to reflect their current care needs. 2. Each month the MAR/TARS will be checked by one nurse and then second checked and co-signed by another. The paper BM sheets have been removed from Birchwood Court and all charting will take place on the electronic kiosks. Physician orders are checked by 2 licensed nurses. An additional check will be completed by the night nurse on all charts with new orders for the previous day. 3. Nursing staff will be educated by September 12th, 2014 on the guidelines for checking placement and administering medications via G tubes, by RN Educator. <p><i>DNS and her designee</i></p> <p><i>ML 8-26-14</i></p>	

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F 281	<p>Continued From page 14</p> <p>Review of Donna D. Ignatavicius and M. Linda Workman, Medical-Surgical Nursing, 7th Ed., St. Louis, MO, 2013, page 1346, revealed, "Check placement before each drug administration."</p> <p>Surveyor: 32332</p> <p>2. Review of resident 3's July 2014 medication administration record (MAR) revealed: *An order for Lidoderm 5 percent (%) patch (for pain). *The patch had not been administered in July. *A large "D/C" (discontinue) had been written in the space where the administration was to have been initialed by the nurse as given.</p> <p>Review of resident 3's June 2014 MAR revealed a note beside the Lidoderm order stated "D/C 6/30/14 when gone."</p> <p>Review of resident 3's physician's orders revealed: *A 5/29/14 order from the provider's pharmacist and signed by the resident's physician to have discontinued the Lidoderm patch and have begun meloxicam (for pain). *A 6/30/14 physician's order summary report had: -Included the discontinued order for Lidoderm patch. -Not included the new order for meloxicam. *A 7/17/14 physician's order summary report had: -Included the discontinued order for Lidoderm patch. -Not included the order for meloxicam. *The discontinued order for Lidoderm patch had carried over to two physician recertification orders indicating he had reordered that medication. *The meloxicam order had not been placed on those recertification orders.</p>	F 281	<p>4. The Director of Nursing and/or her designee will audit 4 nurses' skills each month and a return demonstration will be provided.</p> <p>5. The DNS and/or her designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring.</p> <p>6. The Director of Nursing is responsible for this area of compliance.</p>	9/12/14
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F 281	<p>Continued From page 15</p> <p>Interview on 7/24/14 at 8:55 a.m. with the director of nursing revealed she agreed the physician's orders had not been updated to include medications as ordered.</p> <p>Surveyor: 33265</p> <p>3. Review of resident 10's complete medical record revealed: * A pharmacy consultant report dated 6/24/14 identified: -The resident had been started on Enablex (medication for the bladder) daily in February 2014. -The physician changed to the generic form of the bladder medication which was Ditropan in April 2014. -The resident was seen on 6/11/14 by the physician, and an order had been written to change back to Enablex. -The resident remained on Ditropan after 6/11/14. -The pharmacy had requested clarification if the resident was to change back to Enablex. -On 7/8/14 the assistant DON wrote a note to fax an order for Enablex to the pharmacy.</p> <p>Interview on 7/24/14 at 9:40 a.m. with the DON revealed she agreed the change in the medication order should have been sent to pharmacy in a timely fashion.</p> <p>Surveyor: 32332</p> <p>4. Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St., Louis, Mo., 2013, revealed, page 590: **"It is essential to verify the accuracy of every medication you give to your patients with the patient's orders" **"If the medication order is incomplete, incorrect,</p>	F 281		
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F 281	<p>Continued From page 16 or inappropriate or if there is a discrepancy between the original order and the information on the MAR [medication administration record], consult with the prescriber". Review of the provider's May 2010 General Dose Preparation and Medication Administration policy revealed the need to confirm that the medication administration record reflects the most recent medication order.</p> <p>Surveyor: 32335 5. Review of the Birchwood Monthly BM (bowel movement) Charting records revealed: *Two separate July 2014 records. *Both were incomplete and had missing entries for ten out of twenty-two days.</p> <p>Interview on 7/23/14 at 8:10 a.m. with certified nursing assistant G revealed: *He was not sure why there were two July 2014 charting sheets. *The night shift "sometimes" completed a separate one.</p> <p>Interview and record review on 7/24/14 at 9:30 a.m. with the director of nursing (DON) revealed: *She was not sure why two separate charting sheets had been used. *She agreed there had been "holes" (areas not completed) in the documentation. *The charge nurse should have been reviewing the charting sheets, but there was no way to verify that had occurred. *They had no policy and procedure regarding the monthly charting sheets.</p>	F 281		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309 F 309 SS=E	Continued From page 17 483.25 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: 33265 Based on record review, interview, and guidelines review, the provider failed to combine dialysis and hospice care plans with provider care plans for: *Two of four hospice sampled residents (13 and 18). *One of one dialysis sampled resident (1). Findings include: 1. Review of resident 1's complete medical record revealed two separate care plans. *The dialysis center's care plan was dated 7/14/14. *The provider's care plan was dated 7/15/14 and had not had the following: -No emergency measures were identified such as what to do if bleeding occurred from the shunt (area used to access venous system for dialysis). -No daily checking of the shunt area was suggested. 2. Review of resident 13's complete medical record revealed two separate care plans. *The provider's care plan was dated 5/29/14 only listed hospice care consult as indicated.	F 309 F 309	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. <i>ML 8-26-14</i> Without waiving the foregoing statement, the facility states with respect to: 1. Resident #18 has been discharged. Resident #13 and #1 care plans have been updated to reflect hospice and dialysis integration. 2. All residents on hospice or dialysis have updated integrated care plans. 3. By September 12 th , 2014 the MDS Coordinators' will be educated on integrating care plans for services <u>like hospice and dialysis</u> . <i>By appropriate Clinical Review</i> The DNS and/or her designee will audit 2 resident care plans a week for two months to ensure integration is completed. (there are currently only 6 charts this applies to. We will run out of charts to review prior to the 2 months) 5. The DNS and/or her designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring. 6. The Director of Nursing is responsible for this area of compliance.	9/12/14	

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F 309	<p>Continued From page 18</p> <p>*Hospice care plan was dated 5/16/14 and totally separate from provider's.</p> <p>3. Review of resident 18's complete medical record revealed two separate care plans.</p> <p>*Resident was admitted on 4/18/14.</p> <p>*The provider's care plan was dated 2/11/14 and had been from a previous admission that had not included hospice.</p> <p>*The hospice care plan was dated 5/29/14 and was separate from the provider's care plan.</p> <p>4. Interview on 7/24/14 at 9:40 a.m. with the director of nursing revealed she:</p> <p>*Understood the above care plans should have been combined and not separate.</p> <p>*Agreed there should have been an updated care plan on re-admission.</p> <p>*Believed there had been an updated care plan for resident 18.</p> <p>-Provided a care plan from the computer system with admission date of 4/18/14 which had not been in the complete medical record provided.</p> <p>*Had no policy or procedure for residents on dialysis or hospice.</p> <p>Review of the provider's September 2011 Care Plan guidelines revealed:</p> <p>*All care plans should have included individual and/or combined focus problems.</p> <p>*Anything that was specific to or what would need to be known about the resident to provide care should have been on the care plan.</p> <p>*Care plans were to be multidisciplinary (all providers information together).</p> <p>-Team members should have combined their interventions into the related focus problem.</p> <p>*The regulations stated the care plan was to have been comprehensive (included all information in</p>	F 309		
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<p>F 309</p> <p>F 323 SS=E</p>	<p>Continued From page 19 one place).</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, and policy review, the provider failed to store hazardous chemicals appropriately in one of two shower rooms (C wing), and in one of one storage room (A wing). Findings include:</p> <p>1. Observation on 7/22/14 at 7:40 a.m. and on 7/23/14 at 11:13 a.m. of the storage room at the end of the wing A hall revealed: *The door was unlocked and open on 7/22/14 with the key to the door hanging from the lock. The following were noted: *Multiple hazardous chemicals for the whirlpool tub were in gallon jugs on the floor directly in view upon entering the room. Those included: -Three full and one partially used gallon containers of Apollo Cid-A-L-H disinfectant. -Three full gallon containers of Apollo Terasol - Natural Bath Oil A (for external use only). -Three full gallon containers of Apollo Hygena-Ultra Odor Eliminating Shampoo and body wash.</p>	<p>F 309</p> <p>F 323</p>	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states that with respect to:</p> <ol style="list-style-type: none"> 1. All chemicals have been moved below the personal items. The leaking chemical has been disposed of. Keypads have been added to the storage room on Arbor and the shower room on Arbor. They have been added to the shower rooms and storage room on Country to ensure the doors are always locked. 2. The Nursing departments will be educated by September 12th, 2014 to review the procedure regarding chemical storage and locking storage/bathing rooms. <i>by RN educator.</i> 3. The DNS and/or her designee will audit the storage and bathing rooms weekly for two months to ensure chemicals are properly stored and the doors are locked. <p><i>ML 8-26-14</i></p>	
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F 323	<p>Continued From page 20</p> <ul style="list-style-type: none"> -Three full gallon containers of Apollo Turbo Clean - Predisinfectant Chelating Detergent. *The partially used container of Apollo Cid -A-L H had been leaking. -Sticky residue was on the sides and bottom of the container. -There was a one and a half inch gash in the top edge of the container. -The label said: "danger keep out of reach of children," "hazardous to humans," "do not get on eyes, skin or clothing,"and "causes irreversible eye damage and skin burns." <p>2. Observation on 7/23/14 at 1:35 p.m. in the shower room on C wing revealed:</p> <ul style="list-style-type: none"> *The lock was undone with the key and the lock lying on the top of the storage cabinet near the shower. *On the top of the two shelves in the cabinet there were two spray bottles of 3M Quat Disinfectant (cleaning solution) positioned next to personal care items (shampoo, lotion, soap) and adult disposable incontinent pads with the sprayer directly over the pads. *The label on the disinfectant said: <ul style="list-style-type: none"> -May cause eye and skin irritation. -Avoid eye and skin contact. <p>Interview on 7/24/14 at 9:30 a.m. with the assistant director of nursing regarding the above issues revealed she agreed:</p> <ul style="list-style-type: none"> *The spray bottles of disinfectant should have been stored away from the personal items. *The cabinet containing chemicals should have been locked. *The storage room should have been locked. *Leaking chemical containers should have been disposed of. 	F 323	<ul style="list-style-type: none"> 4. The DNS and/or her designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring. 5. The DNS is responsible for this area of compliance. 	9/12/14

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

PRINTED: 08/05/2014
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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NAME OF PROVIDER OR SUPPLIER ABERDEEN HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401
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F 323	Continued From page 21 Review of the provider's undated and untitled policy (what had been given upon request as the policy on chemical storage) revealed all poisonous or dangerous chemicals and compounds must be stored independently under lock and key.	F 323		
F 332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, manufacturer's guidelines, and policy review, the provider failed to prepare and administer insulin according to manufacturer's guidelines for four of five (residents 20, 21, 22, and 23) insulin administration observations of three of five nurses (RN I, K, and A) resulting in the potential for hypoglycemia (low blood sugar; if left untreated it can cause death). Findings include:</p> <p>1. Observation on 7/22/14 at 11:10 a.m. of registered nurse (RN) I revealed she had administered Novolin R (a short-acting insulin) to resident 20. The resident was not fed until later at 11:50 a.m.</p> <p>Interview on 7/22/14 at 11:50 a.m. with RN I regarding the above insulin administration revealed: *She thought manufacturer's guidelines and the provider's policy allowed for forty-five to sixty</p>	F 332	<i>See next page</i>	

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

PRINTED: 08/05/2014
FORM APPROVED
OMB NO. 0938-0391

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F 332	<p>Continued From page 22</p> <p>minutes for a resident to eat after receiving insulin.</p> <p>*She was unaware of the manufacturer's guideline requirement to eat within thirty minutes of the Novolin R insulin administration to ensure the safety of the resident.</p> <p>Review of the revised March 2009 Food and Drug Administration's copy of the Novolog Nordisk Pharmaceuticals Industries Inc manufacturer's guidelines <http://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=10574>, accessed on 7/28/14, revealed "The injection of Novolin R should be followed by a meal within approximately 30 minutes of administration."</p> <p>2. Observation on 7/23/14 at 7:45 a.m. with RN J during Humulin N (a short- acting insulin) administration to resident 21 revealed she had not: *Rolled the pen ten times between her hands prior to administration to properly mix the insulin as directed by the manufacturer. *Primed the pen with two units of insulin prior to administration (to ensure correct dosing) as directed by the manufacturer. *Put on gloves when she had administered the insulin to the resident.</p> <p>Interview on 7/23/14 at 7:50 a.m. with RN J regarding the above insulin observation revealed she: *Was not aware she needed to roll and prime the insulin pen prior to administration. *Had not been trained by the provider on the use of the insulin pen.</p> <p>Review of the revised December 2013 Eli Lilly</p>	F 332	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states that with respect to:</p> <ol style="list-style-type: none"> 1. Insulin pens are administered per manufacturer guidelines. 2. The Nurses' will be educated by September 12th, 2014 to review the procedure regarding administering insulin pens. 3. The DNS and/or her designee will audit 4 licensed nurses a month for proper usage of insulin pens and a return demonstration will be provided. 4. The DNS and/or her designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring. 5. The DNS is responsible for this area of compliance. <p><i>mu</i> <i>8-26-14</i></p> <p><i>By the RN nurse educator.</i></p>	9/12/14

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

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FORM APPROVED
OMB NO. 0938-039

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F 332	<p>Continued From page 23</p> <p>and Company, manufacturer's guidelines <http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=f6edd793-440b-40c2-96b5-c16133b7a921#section-2.1>, accessed on 7/28/14, revealed the insulin pen should have been rolled ten times and primed with two units of insulin prior to administration.</p> <p>3. Observation on 7/23/14 at 8:10 a.m. with RN K administering Humalog (a rapid-acting insulin) to resident 22 revealed she:</p> <ul style="list-style-type: none"> *Administered insulin in the resident's left deltoid muscle (a muscle on side of the upper arm). *Held the insulin syringe in the resident's skin for two seconds. *Had not put on gloves when she had administered the insulin to the resident <p>Observation on 7/23/14 at 8:20 a.m. with RN K administering Lantus (a long-acting insulin) to resident 23 revealed she had:</p> <ul style="list-style-type: none"> *Not properly performed a safety test (the wasting of 2 units of insulin out of the pen to make sure the needle and syringe had been working properly). *Held the pen in place after administration for five seconds. *Not put on gloves when she had administered the insulin to the resident. <p>Interview on 7/23/14 at 8:28 a.m. with RN K regarding the above insulin administrations revealed:</p> <ul style="list-style-type: none"> *The insulin was to have been given subcutaneously (into the fatty tissue below the skin) in the back of the arm. *She was unaware how much time was needed for each insulin syringe to maintain contact with the resident's skin prior to removing the needle. 	F 332			

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

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FORM APPROVED
OMB NO. 0938-039

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F 332	<p>Continued From page 24</p> <p>*She was unsure how to perform a safety test properly using the Lantus insulin pen. *She should have used gloves when she had administered insulin to the above residents.</p> <p>Review of <http://pi.lilly.com/us/humalog-kwikpen-um.pdf>, accessed on 7/28/14, revealed: "Humalog is injected subcutaneously in the stomach, buttocks, upper legs or upper arms and slowly count to five."</p> <p>Review of the manufacturer's 2014 How to Use your Solostar Pen <http://www.lantus.com/docs/pdf/SoloSTAR-QRG.pdf>, accessed on 7/28/14, guideline's revealed the Lantus pens: *Require a safety test prior to all administrations. *Requires a ten second hold to ensure all the medication had been administered.</p> <p>Review of the provider's January 2005 Medication General Administration Guidelines policy revealed medication administration standards of practice included manufacturer specifications for medication administration.</p> <p>Surveyor: 32332 4. Observation on 7/22/14 at 11:50 a.m. of RN A preparing an insulin administration using a NovaLog FlexPen for resident 26 revealed she: *Uncapped the insulin pen and applied a needle. *Did not prime the pen with an air shot (to ensure proper dosing). *Turned the insulin dial to six units. *Brought the insulin to the resident. *Inserted the needle into the resident's skin and depressed the plunger.</p>	F 332		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2014
FORM APPROVED
OMB NO. 0938-0391

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F 332	<p>Continued From page 25</p> <ul style="list-style-type: none"> *Waited no longer than 3 seconds before removing the needle from the skin. *Waited until 12:55 p.m. before serving the resident his meal. <p>Interview at 12:15 p.m. with RN A regarding her routine revealed that was her normal procedure for using the NovaLog FlexPen. When asked about waiting so long for food after the administration she stated the resident's blood sugars had not normally dropped rapidly, so it would not have been a concern.</p> <p>Interview on 7/24/14 at 8:55 a.m. with the director of nursing revealed she agreed:</p> <ul style="list-style-type: none"> *RN A should have primed the FlexPen prior to drawing up and administering the insulin injection. *RN A should have left the needle in the resident's skin at least 6 seconds. *The resident should have eaten within 5-10 minutes after the insulin administration. <p>Review of the Novo Nordisk NovoLog FlexPen Patient Instruction For Use revised October 2013, http://www.novologpro.com/resources/managing-mealtime.aspx, accessed on 7/22/14 revealed:</p> <p>"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:</p> <ul style="list-style-type: none"> *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. 	F 332		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-039

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<p>F 332</p> <p>F 386 SS=D</p>	<p>Continued From page 26 If not, change the needle and repeat the procedure no more than 6 times."</p> <p>"Keep the needle in the skin for at least 6 seconds, and keep the push-button pressed all the way in until the needle has been pulled out from the skin. This will make sure a full dose has been given."</p> <p>"NovaLog should generally be given immediately (within 5-10 minutes) prior to the start of a meal."</p> <p>483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS</p> <p>The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on record review, interview, and policy review, the provider failed to ensure an order for a sliding scale insulin (amount of insulin changes based on blood sugar level) was signed by a physician for one of one sampled resident (1). Findings include:</p> <p>1. Review of resident 1's complete medical record revealed: *A hand written order for sliding scale insulin was</p>	<p>F 332</p> <p>F 386</p>	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states that with respect to:</p> <p><i>MLK</i> <i>8-26-14</i></p> <ol style="list-style-type: none"> 1. Resident #1 care plan and physician orders have been reviewed and updated per care needs. 2. The Nurses' will be educated by September 12th, 2014 on signing off physician orders and the requirements for a physician order. <i>by RN educator.</i> 3. The DNS and/or her designee will audit 2 charts for the accuracy of transcription and implementation of physician's orders per week for 2 months. 	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FORM APPROVED
OMB NO. 0938-0391

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F 386	Continued From page 27 written on 6/27/14. *No physician's signature was included with the order. *No explanation as to how the medication order was received was documented. *The order was noted by two nurses on 6/27/14. *No time of when the order was written or noted was documented. Interview with the director of nursing on 7/24/14 at 9:40 a.m. revealed she agreed two things were missing from the order: *The time the order was written. *The physician's signature.	F 386	4. The DNS and/or her designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring. 5. The DNS is responsible for this area of compliance.	9/12/14	
F 431 SS=F	Review of the provider's January 2005 Individual Medication Orders policy revealed: *Medications would be administered only upon the clear, complete and signed order of a person lawfully authorized to prescribe. 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.	F 431	<i>See next page</i>		

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

PRINTED: 08/05/2014
FORM APPROVED
OMB NO. 0938-0391

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F 431	<p>Continued From page 28</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: 33488 Based on observation, interview, record review, and policy review, the provider failed to: *Have a system of accountability for all non-schedule II (medications classified II-V depending on their makeup and use) controlled medications (residents 9, 29, 30, 31 and two random residents had medications missing or unaccounted for). *Remove discontinued non-schedule II controlled medications from the medication cart for one of five medication carts located on the C-wing. *Have staff use consistent methods for dispensing medication from randomly identified blister packs in the order received from pharmacy. *Ensure five multiple-use eye drops had been labeled with opened dates in one of five</p>	F 431	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states that with respect to:</p> <ol style="list-style-type: none"> 1. All schedule 2, 3, and 4 narcotics will be counted every shift starting August 18th, 2014. 2. The Nurses' will be educated by September 12th, 2014 to review the procedure regarding counting narcotics every shift. Eye drops are to be dated when opened and all eye drops not dated will be discarded. The pharmacy will begin excluding 31 on the blister cards and the nurses will date the cards when they are put in use. All blister packs will be utilized in the same manor. <i>Education will be provided by RN nurse educator.</i> <p><i>MW 8-26-14</i></p>		

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F 431	<p>Continued From page 29</p> <p>medication carts located on the Transitional Care Unit [TCU] cart resulting in the potential for drug diversion and patient neglect with regard to medication administration.</p> <p>Findings include:</p> <p>1. Observation and medication cart review on 7/23/14 from 1:00 p.m. through 5:00 p.m. and again on 7/24/14 from 7:00 a.m. to 8:30 a.m. of the medication carts located on the C-wing with the director of nursing (DON) revealed: *A total of nine non-scheduled II controlled medications had been missing and unaccounted for during the above random medication cart review. *Some staff had been punching out medications from the blister packs according to date, while others had punched the medications out in a sequential order (one after another).</p> <p>Review of the above medication carts and the medication administration record (MAR) of residents 9, 29, 30, and 31 by the DON and this surveyor revealed documentation had not matched the amount of medication on hand. Review of the following residents' medications revealed: *Resident 29 had a daily scheduled anti-anxiety medication (lorazepam) that was: -Dispensed from the pharmacy on 7/1/14. -The blister pack originally contained thirty tablets. -Only fourteen tablets had been removed from the blister pack. -The MAR had been initialed daily by staff that the medication had been administered to the resident. -There had been no documentation to account for the nine tablets that were supposed to have been</p>	F 431	<p>3. The DNS and/or her designee will audit the medication room/medication carts 2 times a week for two months and then 1 time a week for 1 month for proper storage, medications that are not dated but opened. We will also audit counting of narcotics every shift for compliance with the facility's security policy and procedure on all shifts for three days per week for two months, and then two days a week for one month.</p> <p>4. The DNS and/or her designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring.</p> <p>5. The DNS is responsible for this area of compliance.</p>	9/12/14	

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

PRINTED: 08/05/2014
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F 431	<p>Continued From page 30 administered to the resident but were still in the blister pack.</p> <p>*Resident 30 had six pills of an anti-anxiety medication (alprazolam) that were not accounted for.</p> <p>*Resident 31 had one pill of a hypnotic (medication that induces sleep) called zolpidem that was missing and not accounted for.</p> <p>*Resident 9 had two pills of an anti-anxiety medication (lorazepam) missing and unaccounted for.</p> <p>*Two blister packs of non-scheduled controlled medications of two random residents had been discontinued in 2013 but had not been pulled from the medication carts.</p> <p>Interview with the DON on 7/24/14 at 8:20 a.m. regarding the above medication revealed she agreed:</p> <p>*There were nine medications that were unaccounted for or missing.</p> <p>*There were multiple blister packs that had not been used in the order they were dispensed from the pharmacy.</p> <p>*Her expectation was the discontinued medications would have been removed immediately from the medication chart and disposed of accordingly.</p> <p>*Staff needed to document appropriately and consistently.</p> <p>*There was a failure to ensure the appropriate disposition of non-schedule II controlled medications.</p> <p>Interview on 7/24/14 at 9:50 a.m. with consultant pharmacist L regarding the above medication findings revealed:</p> <p>*She had not audited the medication carts or the medication room.</p>	F 431		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2014
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F 431	<p>Continued From page 31</p> <p>*It was her expectation nursing staff were responsible for accountability of non-schedule II controlled medications.</p> <p>*She was unaware what the controlled substance policy of [pharmacy name] contained.</p> <p>*She had no knowledge of any regulation requiring the accountability for non-schedule II controlled medications.</p> <p>Surveyor: 32332</p> <p>2. Observation on 7/23/14 at 10:15 a.m. of schedule III and IV medications on the Transitional Care Unit cart on Arbor Avenue with RN B revealed resident 13 had one blister pack of PRN alprazolam (medication for anxiety). *The blister pack containing thirty tablets was delivered on 6/18/14. *Six tablets had been removed from the blister seals. *Review of resident 13's June 2014 through July 2014 MARs revealed five tablets were documented as given. One tablet had not been accounted for.</p> <p>3. Observation on 7/23/14 at 10:55 a.m. of schedule III and IV medications on the Long Cart on Arbor Avenue with RN B revealed resident 3 had one blister pack of lorazepam (a medication for anxiety). *The blister pack containing thirty tablets was delivered on 6/22/14. *Nineteen tablets had been removed from the blister seals. *Review of resident 3's June 2014 through July 2014 MARs revealed fifteen tablets had been documented as given. Four tablets had not been accounted for.</p>	F 431			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 431	<p>Continued From page 32</p> <p>4. Observation on 7/23/14 at 4:45 p.m. of routinely ordered and as-needed (PRN) schedule III and IV medications on the Memory Support Unit, Birchwood Court, with assistant DON revealed:</p> <ul style="list-style-type: none"> *Resident 27 had an order for lorazepam 0.5 mg TID (to be given three times daily). *One blister pack had been delivered on 5/3/14. -That blister pack had 20 empty blister seals. -Ten tablets remained in the seals. <p>A delivery receipt for lorazepam 0.5 mg, ninety tablets (three blister packs) had been delivered from the pharmacy on 6/21/14 and revealed the following:</p> <ul style="list-style-type: none"> *The first blister pack tablets were to have been given in the morning had originally contained thirty tablets. -That card had fifteen empty blister seals. -Fifteen tablets remained in the seals. *The second blister pack contained thirty tablets that were to have been given at 2:00 p.m. -That card had nineteen empty blister seals. -Eleven tablets remained in the seals. *The third blister pack delivered on 6/21/14 was not present. <p>A delivery receipt for lorazepam 0.5 mg, ninety tablets (three blister packs) had been delivered on 7/14/14 and revealed the following:</p> <ul style="list-style-type: none"> *The first blister pack to have been given in the morning had originally contained thirty tablets. -That blister pack contained all thirty tablets. *The second blister pack to have been given at noon had originally contained thirty tablets. -That card had two empty blister seals. -There were twenty-eight tablets remaining in the blister seals. *The third blister pack delivered on 7/14/14 had 	F 431		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2014
FORM APPROVED
OMB NO. 0938-039

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F 431	<p>Continued From page 33 not been present.</p> <p>Interview on 7/23/14 at 5:00 p.m. with the assistant DON revealed: *She was unsure why there had been lorazepam tablets remaining from the May and June 2014 blister packs. *Those blister packs should have been used during the months they had been received. *She did not know where the third blister pack issued on 7/14/14 had been. *There had not been a system in place to account for the medications.</p> <p>Surveyor: 33488 Review of the January 2005 [pharmacy] Controlled Substances policy revealed: *"The pharmacist or designee will make regular checks of the handling, storage, recording, and disposal of controlled substances." *"Controlled substances must have an entry made in the resident's medical record when received. The director of nursing or designee will conduct a physical inventory and reconciliation of all controlled substances in the facility."</p> <p>Surveyor: 32332 5. Review on 7/23/14 at 10:15 a.m. of the TCU medication cart revealed five random resident's bottles of eye medication with no opened dates, to indicate when the bottles had been opened.</p> <p>Interview at that time with RN A revealed her expectation had been the bottles were to have been labeled to identify when they had been opened.</p> <p>Interview on 7/24/14 at 8:15 a.m. with the DON revealed it was her expectation all multi-use</p>	F 431		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2014
FORM APPROVED
OMB NO. 0938-0391

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F 431	Continued From page 34 medications would have been labeled with the date it had been opened. Review of the provider's September 2009 Storage and Expiration Dating of Drugs, Biologicals, Syringes, and Needles policy revealed "Once any drug or biological package is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program 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. (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.	F 441	<i>See next page</i>	

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

PRINTED: 08/05/2014
FORM APPROVE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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F 441	<p>Continued From page 35</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 A. Based on observation, interview, and policy review, the provider failed to: *Use the proper chemical to disinfect a room by housekeeping for one of one sampled resident (28) with clostridium difficile (c.difficile) (a highly contagious bacterial infection). *Appropriately sanitize hands between resident medication administration by two of five nurses (registered nurse [RN] J and RN K) for 12 of 44 observed medication administrations. *Use gloves by two of four nurses (RN J and RN K) for administering three of four resident's (21, 22, and 23) insulin injections. Findings include:</p> <p>1. Observation and interview on 7/22/14 at 8:00 a.m. revealed resident 28 had a "contact precautions" sign placed on her door. Interview with RN A revealed resident 28 was being treated for a c.difficile infection and was on isolation precautions.</p> <p>Interview on 7/23/14 at 2:00 p.m. with housekeeper C revealed she used a spray bottle</p>	F 441	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states with respect to:</p> <ol style="list-style-type: none"> The gloving and hand washing guidelines have been reviewed. A guideline has been updated for the disinfecting of restorative equipment. All employees ^{will be} have been educated by September 12th, 2014 on proper hand washing, gloving, disinfecting of the restorative equipment, and the housekeeping guideline for disinfecting rooms, ^{by RN nurse educator.} The DNS and/or her designee will audit three times per week for two months for the proper disinfecting of the restorative equipment. Another audit will be completed 2 times per week for one month and then 1 time per week for one month. C.N.A, nursing and UAP staff members for proper hand washing, hand hygiene, and glove use during medication passes. 	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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F 441	<p>Continued From page 36</p> <p>labeled 'Quat 5L' to disinfect resident 28's room and any other rooms that might have c. difficile. When asked if she used bleach products for any disinfection she stated they had used Comet with bleach at one time. She had been instructed the Quat (quaternary ammonium) products had been as effective as the bleach to disinfect c. difficile.</p> <p>Interview on 7/23/14 at 3:20 p.m. with the housekeeping supervisor revealed she had previously been instructed the quat product disinfected everything, but she had been misinformed. When she called to clarify that she had been instructed to use a 1:10 (one to ten) bleach solution.</p> <p>Review of the provider's undated Clostridium difficile Policy and Procedure revealed a 1:10 bleach solution mixed daily was to have been used for environmental cleaning.</p> <p>Review of APIC Text of Infection Control and Epidemiology, 3rd Ed., Association for Professionals in Infection Control and Epidemiology, Inc., Washington, DC, 2009, page 100-4, revealed only chlorine-containing disinfectants were effective for killing c. difficile.</p> <p>Surveyor: 33488</p> <p>2. Observation and interview on 7/22/14 from 10:00 a.m. to 10:30 a.m. with RN J when she administered medications for twelve of forty-four medication administration observations revealed: *She had not washed her hands with soap and water or used hand sanitizer between observations. *She agreed she should always wash her hands or use hand sanitizer when completing a task and</p>	F 441	<p>4. The DNS and/or her designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring.</p> <p>5. The DNS is responsible for this area of compliance.</p>	9/12/14
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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F 441	<p>Continued From page 37 before starting a new one.</p> <p>3. Random observations and interview on 7/22/14 and 7/23/14 from 7:00 a.m. through 12 noon with RNs J and K during three of four insulin observations for residents 21,22, and 23 revealed: *They had not worn gloves when they administered the insulin. *They agreed they should have followed standard glove usage for safety and infection control.</p> <p>Review of the provider's undated Standard Precautions-Overview policy revealed: *Hand-washing was to have been performed before touching medication to be given to a resident. *Gloves were to have been worn when exposure to blood or bodily fluids was likely.</p> <p>Surveyor: 32335 B. Based on observation, interview, and policy review, the provider failed to disinfect and clean one of one NuStep exercise machine in the restorative room between resident use resulting in the potential for cross-contamination. Findings include:</p> <p>1. Observation on 7/22/14 from 11:10 a.m. through 11:35 a.m. in the restorative room revealed: *An unidentified resident had gotten off the NuStep machine. *At 11:15 a.m. resident 32 had gotten on the NuStep. *No cleaning or disinfecting had been done between the residents.</p>	F 441		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2014
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 38</p> <p>Observation on 7/22/14 from 4:00 p.m. through 4:15 p.m. in the restorative room revealed: *At 4:00 p.m. resident 33 had gotten off the NuStep exercise machine. *At 4:10 p.m. resident 34 had gotten on the NuStep and started to exercise. *No cleaning or disinfecting had been done between the residents.</p> <p>Interview on 7/22/14 at 4:15 p.m. with restorative aide N revealed she was not sure how many people had used the machine that day. She had not cleaned or disinfected the NuStep machine in between residents. She should have disinfected the machine between residents as that was how she had been taught.</p> <p>Interview and policy review on 7/23/14 at 10:30 a.m. with the registered nurse educator revealed the restorative aide should have been disinfecting the NuStep machine between residents.</p> <p>Review of the provider's January 2010 Rehabilitation Services Policy for Infection Control policy revealed: **Resident care equipment will be decontaminated after each resident use with a facility approved disinfectant." **Equipment will be cleaned and maintained between resident use as per manufacturer's recommendations."</p>	F 441		
F 514 SS=E	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;</p>	F 514	<i>See next page</i>	

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

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F 514	<p>Continued From page 39</p> <p>accurately documented; readily accessible; and systematically organized.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on record review, interview, and policy review, the provider failed to ensure: *Consistent documentation for a physician ordered repositioning for 1 of 15 sampled residents (1). *Incomplete documentation of the need for a tuberculosis skin test on the admission Mantoux testing form for 3 of 15 sampled residents (1, 17, and 18). *Documentation that identified where resident's personal belongings, other than money, went when a resident was transferred or discharged for 2 of 3 sampled transferred or discharged residents (17 and 18). *Complete documentation on a transfer/discharge form for 1 of 3 transferred or discharged sampled residents (17). *Current physician's orders were sent to the pharmacy for 1 of 15 sampled residents (10). *A physician's signature for a significant medication (small difference in amount can have effect on resident) order for 1 of 15 sampled residents (1). Findings include:</p>	F 514	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states with respect to:</p> <ol style="list-style-type: none"> 1. Resident #17, #18 have been discharged from the facility. Resident #1's care plan has been updated to reflect turning and repositioning cares. 2. All residents have an inventory list to document and track their belongings. 3. All employees have been <i>will be</i> educated by September 12th, 2014 on sending medications to the pharmacy, resident inventory list, and signing off physician orders, <i>by RN nurse educator.</i> 4. The DNS and/or her designee will audit 2 charts per week for current inventory list for 2 months, 2 charts for the accuracy of transcription and implementation of physician's orders per week for 2 months, and 2 Care Plans per week to confirm current care plan is in the chart and updated. 	

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

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OMB NO. 0938-0391

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F 514	<p>Continued From page 40</p> <p>1. Review of the turning/toileting schedule form at resident 1's bedside revealed: *Information from 7/13/14, 7/15/14, 7/19/14, 7/20/14, and 7/22/14. *Twelve lines were to have been filled in each day, one for each two hour period when the resident was to have been repositioned. *There had been no documentation of repositioning in some of the two hours blocks of time on the following days: -Six blank lines on 7/13/14. -Eight blank on 7/15/14. -Eleven blank on 7/19/14. -Eight blank on 7/20/14. -Ten blank on 7/22/14.</p> <p>2. Review of the admission Mantoux (tuberculosis) testing form for residents 1, 17 and 18 revealed: *The question identifying whether a skin test for tuberculosis should be done or not was not answered for any of these residents. *The skin tests had been completed on all three residents.</p> <p>3. Review of residents 17 and 18's complete medical records revealed there had been no documentation identifying where the residents personal belongings went after transfer or discharge. *Resident 17 had been transferred to the hospital without her coat or suitcase on 4/9/14. -A nurse's note on 4/11/14 stated the family were to pick-up the belongings. -The resident's valuables inventory form had not had the discharge section filled in identifying where the belongings went. -No further documentation on the belongings was found.</p>	F 514	<p>5. The DNS and/or her designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring.</p> <p>6. The DNS is responsible for this area of compliance.</p>	9/12/14

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

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FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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F 514	<p>Continued From page 41</p> <p>*Resident 18 had died on 7/21/14 and was transported to the funeral home without his belongings.</p> <p>-A watch, two rings, and a necklace were noted on 7/21/14 at 4:06 a.m. to have been placed in an envelope and placed in the locked box in the medication cart.</p> <p>-Neither medication cart contained an envelope with jewelry.</p> <p>-No further documentation of the location of the jewelry was found.</p> <p>4. Review of the complete medical record for resident 17 revealed three incomplete documents (transfer/discharge report, resident valuables inventory, and medication return/disposal document). Refer to F 202, finding 1.</p> <p>5. Review of the complete medical record for resident 10 revealed the physician's medication order had not been forwarded to the pharmacy in a timely manner. Refer to F 281, finding 2.</p> <p>6. Review of resident 1's complete medical record revealed a medication order for sliding scale insulin had been noted by two nurses and entered into the medical record without a physician signature. Refer to F 386, finding 1.</p> <p>Interview, record review, and policy review for above findings on 7/24/14 at 9:40 a.m. with the director of nursing revealed she agreed:</p> <p>*Provider polices on documentation had not been followed.</p> <p>*There were multiple documentation errors identified on the above documents.</p>	F 514		

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

ORIGINAL

PRINTED: 07/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2014
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NAME OF PROVIDER OR SUPPLIER ABERDEEN HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/23/14. Aberdeen Health and Rehab was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K062 and K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>Addendums noted with an asterisk per 8/10/14 telephone to facility administrator. LF/SDDOH/ME</p>	
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on record review and interview, the provider failed to ensure a flow switch for the automatic sprinkler system was maintained in reliable operating condition. Findings include:</p> <p>1. Review of the provider's automatic sprinkler system quarterly inspection report dated April 2014 revealed a flow switch had failed during that test. The sprinkler service company had provided comments on that report regarding the failed flow switch to the provider. Interview on 7/23/14 at</p>	K 062	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states that with respect to:</p> <ol style="list-style-type: none"> 1. The sprinkler flow switch was replaced on 7/30/14. 2. The Maintenance Supervisor and/or his designee will review and note all inspection reports quarterly. <p>* [Redacted] see page 1a LF/SDDOH/ME</p>	9/12/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Megan Keen</i>	TITLE <i>Eve Director</i>	(X6) DATE <i>8-18-14</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 120 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.

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: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER ABERDEEN HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/23/14. Aberdeen Health and Rehab was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K062 and K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on record review and interview, the provider failed to ensure a flow switch for the automatic sprinkler system was maintained in reliable operating condition. Findings include: 1. Review of the provider's automatic sprinkler system quarterly inspection report dated April 2014 revealed a flow switch had failed during that test. The sprinkler service company had provided comments on that report regarding the failed flow switch to the provider. Interview on 7/23/14 at	K 062	* 3. The Maintenance Director and/or his designee will present data collected to the Quality Assurance Quality Improvement committee quarterly for further recommendations regarding system and continued monitoring. LF/SDDOH/MF *4 The Maintenance supervisor is responsible for this area of compliance. LF/SDDOH/MF	

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

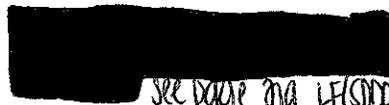
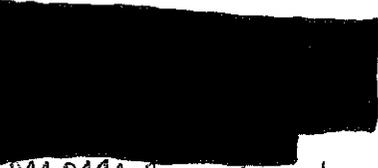
TITLE

(X6) DATE

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.

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

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NAME OF PROVIDER OR SUPPLIER ABERDEEN HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062 K 069 SS=D	<p>Continued From page 1</p> <p>8:15 a.m. with the maintenance supervisor at the time of record review revealed he was informed the flow switch had failed.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334</p> <p>Based on document review and interview, the provider failed to ensure the kitchen hood fire suppression system was tied to the building fire alarm signaling system for one of one kitchen hood. Findings Include:</p> <p>1. Document review of the commercial kitchen equipment inspection report dated 6/26/14 revealed the inspection service company had provided a comment indicating the kitchen hood fire suppression system was not tied into the buildings fire alarm signaling system. Interview with the maintenance supervisor at 9:00 a.m. on 7/23/14 at the time of at record review revealed he was unaware of the comment. He further stated he was not aware of that requirement and indicated the issue had not been addressed.</p>	K 062 K 069	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.</p> <p>Without waiving the foregoing statement, the facility states that with respect to:</p> <p>X  <i>see page 3rd LFISDDHMF</i></p> <p>2. The Maintenance Supervisor and/or his designee will audit the kitchen hood by visual inspection weekly for 2 months.</p> <p>X  <i>see page 3rd LFISDDHMF</i></p>	9/12/14

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NAME OF PROVIDER OR SUPPLIER ABERDEEN HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401	
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K 062	Continued From page 1 8:15 a.m. with the maintenance supervisor at the time of record review revealed he was informed the flow switch had failed.	K 062		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on document review and interview, the provider failed to ensure the kitchen hood fire suppression system was tied to the building fire alarm signaling system for one of one kitchen hood. Findings Include: 1. Document review of the commercial kitchen equipment inspection report dated 6/26/14 revealed the inspection service company had provided a comment indicating the kitchen hood fire suppression system was not tied into the buildings fire alarm signaling system. Interview with the maintenance supervisor at 9:00 a.m. on 7/23/14 at the time of at record review revealed he was unaware of the comment. He further stated he was not aware of that requirement and indicated the issue had not been addressed.	K 069	* 1. The kitchen hood fire suppression system is tied to the fire alarm signaling system as of 7/30/14. LF/SDDOH/MF * 3. The Maintenance Director and/or designee will present data collected to the Quality Assurance Quality Improvement committee quarterly for further recommendations regarding system and continued monitoring. LF/SDDOH/MF	

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10587	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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NAME OF PROVIDER OR SUPPLIER ABERDEEN HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 N HWY 281 ABERDEEN, SD 57401
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Surveyor: 32334 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/22/14 through 7/24/14. Aberdeen Health and Rehab was found not in compliance with the following requirements: S195.	S 000		
S 195	44:04:03:02 GENERAL FIRE SAFETY Each licensed health care facility covered under this article must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of its occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The fire alarm system must be sounded each month. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32334 Based on record review and interview, the provider failed to maintain current certification for one of three boilers (hot water heater). Findings include: 1. Review of the three boiler certificates at 1:15 p.m. on 7/23/14 revealed the boiler certificate for the hot water heater had expired in 2013. Interview with the maintenance supervisor at the time of the document review revealed he was unaware the certificate had expired. He did not indicate that those certificates were checked at a regular interval.	S 195	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states with respect to: 1. The current boiler inspection report is in the boiler room. It expires in 2015. 2. The Maintenance Director and/or his designee will monitor those certificates every 6 months to ensure they are current and on display. 3. The Maintenance Director and/or his designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring. 4. The Maintenance Director is responsible for this area of compliance.	9/12/14

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

TITLE

(X6) DATE

Megan Kleinsasser

Eve Director

RECEIVED

If continuation sheet 1 of 2

AUG 20 2014

SD DOH L&C

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10587	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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