

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10594	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/13/2014
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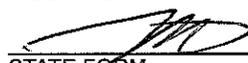
NAME OF PROVIDER OR SUPPLIER BELLE FOURCHE HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 13TH AVENUE BELLE FOURCHE, SD 57717
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/29/14 through 7/31/14 and from 8/12/14 through 8/13/14. Belle Fourche Healthcare Center was found not in compliance with the following requirements: S166 and S355.	S 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance. S166 1. The light bulbs have a protective cover installed over them. 2. All residents have the potential to be affected. 3. The Director of Plant Operations was made aware of the requirement to ensure light bulbs are shatterproof or	9-12-14
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence	S 166		

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

TITLE

(X6) DATE



Interim Administrator

STATE FORM

6899

0Y5R11

RECEIVED

SEP 02 2014

SD DOH L&C

If continuation sheet 1 of 4

South Dakota Department of Health

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S 166	<p>Continued From page 1</p> <p>when the door is closed; (7) Portable space heaters and portable halogen lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to install light bulbs with lens covers or shatterproof bulbs for two of three (300 and 400 wing) housekeeping/supply closets. Findings include:</p> <p>1. Observation on 8/13/14 from 8:15 a.m. to 9:30 a.m. revealed the light bulbs in the 300 and 400 wings housekeeping/supply closets had energy efficient compact fluorescent light bulbs. Those bulbs had no covers and were not shatterproof. Interview with the director of plant operations at the time of the observation confirmed those findings. He stated the provider had made updates to become more energy efficient. He was unaware those light bulbs must be shielded or shatterproof.</p>	S 166	<p>have protective covers installed over bulb when energy efficient bulbs are used.</p> <p>4. The Director of Plant Operations or designee will audit 4 random areas weekly to ensure light bulbs are either shatter proof or have a protective covering in place. Audits will continue weekly for 4 weeks and then monthly X2. Results of audits will be discussed by the DON at monthly Quality Assurance Process Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>5. September 12, 2014</p>	

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S 355	Continued From page 2	S 355		
S 355	<p>44:04:12:05 PROVISION OF SOCIAL SERVICES</p> <p>A nursing facility must provide or make arrangements to provide social services for each resident as needed. A staff social worker or social service designee must be designated as responsible to facilitate the provision of social services. If the staff member is not a social worker, the facility must have a written agreement with a social worker for consultation and assistance to be provided on a regularly scheduled basis but at least quarterly.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 29162 Based on interview and review of the consultant social worker agreement, the provider failed to ensure the social worker (SW) consultant provided consultation and assistance to the social service designee (SSD) at least quarterly. Findings include:</p> <p>1. Interview on 8/13/14 at 10:30 a.m. with the SSD revealed: *The SW came and saw residents the SSD and SW thought needed services. *The SW notes from those visits had been in the individual resident's records. *The SW did not meet with the SSD at least quarterly and review her work and the overall social service department with her. *She was unsure when the SW had been to see the residents. *She thought maybe the administrator would</p>	S 355	<p>S355</p> <p>1. A social work consultant has met with the Social Worker and consulted with her about the social service department processes and procedures.</p> <p>2. All residents have the potential to be affected.</p> <p>3. An arrangement has been obtained with Social Work Consultant who will review the Social Service Director's work and provide quarterly written reports on the activities, observations and recommendations concerning the social services department.</p> <p>4. The Administrator or designee will ensure a written report is received after each social work consultant visit and that visits occur no less than quarterly. Any concerns will be discussed by the Administrator at the monthly Quality Assurance Process Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>5. September 12, 2014</p>	9-12-14

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S 355	<p>Continued From page 3</p> <p>know when the SW had been there, as she had to approve the billing for her services.</p> <p>Interview on 8/13/14 at 1:00 p.m. with the director of clinical services consultant revealed the SW consultant had only been seeing residents. She had not been consulting with the SSD regarding the SS department process and procedure. He stated they (SSD and SW) thought the SW only needed to see residents.</p> <p>Review of the provider's Consultant Social Worker Agreement dated and signed on 11/13/13 by the administrator and consulting social worker revealed the social worker was to:</p> <p>*Have overseen the:</p> <ul style="list-style-type: none"> -Development of residents' social histories, assessments, and care plans. -"Interdisciplinary care plan meetings and progress notes which related to each resident's care plan when necessary and make recommendations." -Discharge planning when appropriate. <p>*Have provided at least "Quarterly written reports on the activities, observations and recommendations concerning the social services department to the administrator and social services coordinator."</p>	S 355		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 000	<p><i>Additional comments noted with an asterisk per 9/14/14 telephone to facility interim DON! KW/SDDOH/MF</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 26632 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/29/14 through 7/31/14 and from 8/12/14 through 8/13/14. Belle Fourche Healthcare Center was found not in compliance with the following requirements: F151, F166, F176, F223, F226, F250, F253, F280, F309, F314, F323, F431, F441, F490, F514, and F520.</p>	F 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.	
F 151 SS=E	<p>483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on group interview, staff interview, and policy review, the provider failed to ensure 5 of 11 (1, 5, 17, 18, and 19) residents who participated in the group interview were invited to attend their regularly scheduled care conferences (meeting). Findings include:</p> <p>1. Group interview on 7/29/14 at 3:05 p.m. with eleven randomly selected residents revealed five residents (1, 5, 17, 18, and 19) had not been invited to their interdisciplinary care conference. All five of those residents were unaware a meeting for their individualized plan of care took</p>	F 151	<p>F151</p> <p>1. No immediate corrective action could be taken for residents 1, 5, 17, 18, and 19.</p> <p>2. All residents have the potential to be affected.</p> <p>3. The Social Service Director has been in-serviced by the Director of Clinical</p>	9-12-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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[Signature] *Interim Administrator* **RECEIVED** 8-27-14

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 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.

SD DOH LSC
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F 151	Continued From page 1 place on a regularly scheduled basis. Interview on 8/12/14 at 10:00 a.m. with the social service designee revealed she had not invited: *Resident 1 to her care conference, because the resident's daughter came to the meeting. She stated resident 1 had told her in the past she did not want to come, so she had not invited her again. *Resident 5 to her care conferences meetings. She was not sure why she had not invited her to the meetings. *Resident 17 to any of his care conference meetings, because she invited his family instead. She stated she had not asked the resident if he wanted to attend the meetings. *Resident 18 to her care conference meetings. She stated she had not asked the resident if he wanted to attend the meetings. *Resident 19 to her care conference meetings. She stated she had not asked the resident if he wanted to attend the meetings. Review of the provider's last revised April 2013 Care Planning Process policy revealed: *The care plan must be prepared by a team that included the participation of the resident. *The care conference was to have been "A time of discussion of the resident's care among the staff, the resident, and/or his family." Review of the revised August 2011 Briggs Healthcare, Resident Rights form presented to residents at the time of admission by the provider revealed the resident "Must be informed of and may participate in planning of your care and treatment."	F 151	Services of the requirement to invite residents to their care plan meeting. 4. The Administrator or designee will audit all scheduled care conferences each week to ensure the resident has been extended an invitation. Audits will continue weekly for 4 weeks and then monthly. Results of audits will be discussed by the Administrator at monthly Quality Assurance Process Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audit. 5. September 12, 2014 <i>*for two quarters. KN/SDDH/MT</i>	
F 166	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO	F 166		

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F 166 SS=F	<p>Continued From page 2 RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059</p> <p>Surveyor: 20031 Based on document review, resident group interview, staff interview, and policy review, the provider failed to inform 12 of 12 (1, 5, 7, 17, 18, 19, 20, 21, 23, 24, 25, and 26) residents of any resolution to resident council grievances and/or individual resident or visitor concerns for the previous eight months (January 2014 through August 2014). Findings include:</p> <p>1. Review of the following resident council meeting minutes revealed: *1/8/14: -Dietary: "Residents are enjoying the music in the dining room daily." -Old Business: "None at this time, all issues have been addressed and resolved." -New Business: "One resident complained that her bathroom is not cleaned up after CRAs (certified resident assistants) do cares with her roommate. This will be addressed." *2/5/14: -Dietary: "Some residents feel that they are not getting enough to eat for supper. ___ (dietary manager [DM]) informed them the supper menu had changed and if they want more to eat they just have to request it."</p>	F 166	<p>F166</p> <p>1. No immediate corrective action could be taken for affected residents. Grievance resolution is reported to residents/family members.</p> <p>2. All residents have the potential to be affected.</p> <p>3. The Social Service Director and the Activities Director have been in-serviced by the Director of Clinical Services of the Grievance Policy at the time of survey. All staff will be in-serviced by the Director of Nursing (DON) on the Grievance Policy no later than (NLT) September 12, 2014. Those staff members on vacation, sick leave, or casual status will be in-serviced prior to their returning to work.</p> <p>4. The Administrator or designee will audit all grievances each week to ensure residents are informed and satisfied with the resolution. Audits will continue weekly for 4 weeks and then monthly. Results of audits will be discussed by the Administrator at monthly Quality Assurance Process Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>5. September 12, 2014</p>	9-12-14
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for two quarters
KWJ/DHMF

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F 166	Continued From page 3 -Old Business: "All concerns have been addressed/resolved." *3/5/14: -Dietary: "Some residents complained of the noise level in the dining room made by staff during the supper meal. Will relay this concern to management." -Old Business: "All concerns have been addressed/resolved." -New Business: "Some residents had concerns with lights being answered slowly at night. There were also concerns about call lights not being in reach. Will take these concerns to D.O.N. (director of nursing)." *4/2/14: -Dietary: --"There have been complaints from some residents that they are tired of being served soup/sandwiches for every supper." --"One resident asked if steak sauce could be available for use. ___ (DM) will order this." --"Residents have previously requested different music to be played during meals. ___ (DM) did get a new variety of music." --There is still a concern with staff being loud in the dining room during supper. This issue has been directed to D.O.N." -Old Business: --"Residents are still complaining that call lights are not being answered timely during the night. This is being reviewed." --"All other business has been addressed/resolved." 5/7/14: -Dietary: --"There are still complaints about the staff noise level in the dining room during the supper meal. This is being monitored by manager at this time." --"One resident would like to hear more of a	F 166	* A Resident Council Meeting was held on September 3, 2014 and the Interim Administrator was in attendance by invitation. The Grievance Policy was addressed in the group and new grievance forms introduced. Discussed old grievances and group stated that most were resolved (dining room noise, music, wait for meals, snacks, water and snack service, and assistance to activities). Those in attendance agreed that call light response was still an issue and a grievance form was recorded on this issue. Resident 5, 17, 18, 24 were in attendance. Resident 23 and 24 have been discharged. Resident 1 in currently hospitalized. Administrator interviewed affected residents not in attendance. Resident 7 who said the call light response was better for her and would report any further issues. Resident 19, 20, 21 did not have any concerns and stated they would report any concerns. Resident 25 did have concerns about his room and such was recorded on a grievance form. Call light response will be audited <i>KWISDCH/ME</i>		

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F 166	Continued From page 4 variety of music played in the dining room, such as country." --"There was a complaint that supper is served slowly. This will be addressed/monitored." --"Residents were asked if evening snacks are being offered to them daily. Some residents in attendance state that they do get one, others stated that they are no longer getting a snack or being offered one. This issue is being addressed and corrected immediately!" -Old Business: "All old business has been resolved or is currently in the process." -New Business: "One resident had a concern that CRAs aren't cleaning up messes after providing resident care. This will be addressed." 6/4/14: -Dietary: --"The noise level in the dining room has improved." --"There was a complaint that serving time is slow and that not all residents at the same table are getting served at the same time. ___ (DM) will monitor this." -Old Business: "All concerns/complaints have been addressed and resolved." 7/2/14: -Administration: "Residents are still having concerns about call lights not being answered in a timely manner. This will be referred to director of nursing. Some also stated that some staff put residents to bed too early. This has also been directed to D.O.N." -Old Business: "Concerns/complaints have been resolved. Or are in the process." 8/6/14: -Dietary: "There were 2 complaints of having to wait excessive times to be served in the dining room. ___ (DM) will be monitoring these specifically."	F 166			

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F 166	<p>Continued From page 5</p> <p>-Old Business: --"Residents are still having issues with their call lights being answered in a timely manner." --"There is a current quality assurance (QA) study being conducted and staff are being held accountable and educated in each of these issues."</p> <p>Staff attendance at the above meetings included: -The current administrator and interim administrator had attended one meeting each in eight months. -The DM had attended six of eight meetings. -The social services designee had attended five of eight meetings. -The DON, housekeeping/laundry supervisor, or any other administrative staff were not noted in attendance for those eight months.</p> <p>Resident group interview on 7/29/14 at 3:05 p.m. with twelve residents revealed: *They had reported their resident council concerns to the activities director or staff who were in attendance. *They stated the only response they ever seemed to get for a follow-up to their concerns was a "Yes or no," or "It's being looked at," or "It's been resolved." *They stated there had only been a few times an actual detailed response had been given by a staff member. *Throughout the group interview the residents revealed the following were still problems at the facility: -Call lights. -Timeliness of meal service. -Wandering residents. -Meal time noise in the dining rooms had been good, now it had become loud again.</p>	F 166		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2014
NAME OF PROVIDER OR SUPPLIER BELLE FOURCHE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 13TH AVE BELLE FOURCHE, SD 57717		
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F 166	<p>Continued From page 6</p> <p>-Resident 19 stated "After supper they put several residents to bed early. They put my roommate to bed before six. Last night it was 5:55 p.m." Resident 17 stated "I just tell them no." He stated "It seems like the people (residents) who can't speak for themselves, they put to bed and get up early."</p> <p>-Snacks and not refilling or refreshing the water mugs.</p> <p>-The CRAs would not help the activity people get residents to activities. Residents 5, 17, and 19 revealed:</p> <p>--The residents who can get to the activities were okay.</p> <p>--They had to wait for the activities people to go and get all the other residents who want to come to an activity.</p> <p>--They got bored because they sit and wait for the activity to start.</p> <p>--They stated it was not the fault of the activities people as they go as fast as they can. But they also help if a resident needs to go to the bathroom too.</p> <p>Surveyor: 23059 Interview on 7/29/14 at 5:55 p.m. with resident 7 revealed it routinely took staff twenty-five to thirty minutes to answer her call light. She stated there had been three times in the previous month where she had put on her call light around 5:00 a.m. and did not receive any help until approximately 6:30 am. each of those days.</p> <p>Interview on 7/31/14 at 9:35 a.m. with the activities director revealed and confirmed the following: *If the grievance or concern was not related to her department she would relay the information and ask for a response or resolution from the</p>	F 166			

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F 166	<p>Continued From page 7 appropriate person.</p> <p>*The responses from the staff could be abrupt, and residents were not getting the whole story.</p> <p>*Some call lights would take a long time to answer. She stated the longest times appeared to be on the evening and overnight shifts. It had been found some staff would not carry their pagers, and therefore claimed they would not know about the call lights. She felt the DON was aware of the call light problem. An audit had been completed on the call lights by the director of human resources in July 2014. She was unaware if another audit had been completed after the initial audit.</p> <p>Review of the audit reports from 7/17/14 through 7/24/14 revealed:</p> <p>*200 wing: 40% of the lights were answered "Late." Longest time was 46.9 minutes.</p> <p>*300 wing: 53% of the lights were answered "Late." Longest time was 183.3 minutes (3 hours and 3.3 minutes).</p> <p>*400 wing: 47% of the lights were answered "Late." Longest time was 108.5 minutes (1 hour and 48.5 minutes).</p> <p>*Resident 5: Light was answered "Late" 56% of the time. Longest time was 27.8 minutes.</p> <p>*Resident 17: Light was answered "Late" 58% of the time. Longest time was 71.1 minutes (one hour and 11.1 minutes).</p> <p>*Resident 23: Light was answered "Late" 60% of the time. Longest time was 19.5 minutes.</p> <p>*No provider definition was given for what constituted "Late" for answering call lights.</p> <p>*Continued interview with the activities director revealed:</p> <p>--When she had come back to do evening activities she had noticed some residents had been put to bed early. She stated "It appeared</p>	F 166		
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F 166	<p>Continued From page 8</p> <p>those that can't speak for themselves are in bed." --Some aides would hurry to get residents to bed or up early, so they could do "Other things" and did not elaborate on what those were.</p> <p>During the above interview with the activities director she also revealed:</p> <ul style="list-style-type: none"> -The DM was working on the timeliness of meals and service. -The DM had tracked snacks about three months ago in May 2014 due to resident complaints. She was not aware staff had not been delivering snacks to some residents again. She was unaware if another audit had been completed after the initial audit. She was also unaware the aides were not keeping the water mugs filled or replaced with fresh water. *Resident 11 would wander a lot in the facility. She stated she tried to keep him busy in the activity room when she could. But when she was busy or when she would leave for the day she was unaware what other staff would do for resident 11's wandering. *The CRAs would not help or offer to get residents to activities. She stated she and her assistant were also CRAs. She said a lot of the times she and her assistant would need to help a resident with care before the resident came to activities. She was aware other more independent residents would wait while she and her assistant helped those residents who needed more care. *She was not aware if management had responded to the customer complaint. <p>Surveyor: 29162 Interview on 7/30/14 at 11:00 a.m. with the DM revealed:</p> <ul style="list-style-type: none"> *There were two seatings for each meal. There was not enough seating at the tables in the dining 	F 166		

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F 166	<p>Continued From page 9</p> <p>room for all residents to have been served at the same time.</p> <p>*The second seating started approximately thirty minutes after the first seating.</p> <p>*The residents who ate first could stay and socialize.</p> <p>*She had informed the residents at the resident council meetings it was "Perfectly fine for them to stay and socialize after they ate."</p> <p>*She agreed:</p> <ul style="list-style-type: none"> -Those residents who wanted to stay and socialize continued to leave as soon as they were done eating. -Those same residents left the dining room, because they knew someone else needed a place at a table to eat. -There had not been an effective solution presented to the resident council for residents that wanted to socialize after meal times. <p>Review of a committee's quality measure (QM) action plan dated 7/14/14 revealed the topic was customer satisfaction surveys. Under the findings area was the following: "One complaint of staff members being rough and mean, and when they were confronted about it, they smirked and walked out." Nothing was noted under "Recommendations" or "Actions/Follow-Up."</p> <p>Review of the undated Long Term Care Facilities Resident's Bill of Rights provided to residents upon admission revealed:</p> <ul style="list-style-type: none"> *Residents "May voice grievances without discrimination or reprisal." *"The grievance process must include the facility's efforts to resolve the grievance, documentation of the grievance, names of the people involved, nature of the matter and the date." 	F 166		

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F 166	Continued From page 10 "Retire and rise when you wish."	F 166	<p>A self administration of Medication Assessment was completed for Resident 7. KW/SDDDH/MF</p> <p>F176</p> <p>1. No immediate corrective action could be taken for Res 7. *</p> <p>2. All residents have the potential to be affected.</p> <p>3. The nurses will be in-serviced by the DON NLT September 12, 2014 on the self-administration of medication policy. Those nurses on vacation, sick leave, or casual status will be in-serviced prior to their return to work.</p> <p>4. The DON or designee will audit to ensure that each resident who self administer medications has a physician order to do so, has an assessment to ensure medications can be self-administered safely, and the care plan is updated. Audits will continue weekly for 4 weeks and then monthly. Results of audits will be discussed by the DON at monthly Quality Assurance Process Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>5. September 12, 2014 * for two quarters. KW/SDDDH/MF</p>	9-12-14	
F 176 SS=D	<p>8. Review of the provider's January 2014 Answering Call Lights policy revealed: "Answer the resident's call as soon as possible." "Be courteous in answering the resident's call."</p> <p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on record review, interview, and policy review, the provider failed to ensure one of one resident (7) had been assessed to be capable of safely self-administering her own insulin while out of the facility. Findings include:</p> <p>1. Review of resident 7's 7/15/14 self medication assessment revealed she: *Did not have the cognitive (memory skills) or functional (able to perform) abilities to self-administer medications. *Was not able to take medications by herself. *Was able to take medications with her in an envelope to dialysis.</p> <p>Review of resident 7's 7/21/14 nurse's note revealed three units of Novolog insulin had been given to her in a syringe to "Give herself as she is going to lunch with a friend."</p>	F 176			

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F 176	Continued From page 11 Interview on 7/30/14 at 1:50 p.m. with the director of nursing and the director of clinical services revealed resident 7 had been assessed as only being capable of taking medications with her in an envelope to dialysis. They confirmed she should not have been given the insulin to take with her and self-administer on her own. Interview on 7/31/14 at 8:10 a.m. with the Minimum Data Set coordinator who completed the self-medication assessment stated she was not aware resident 7 had taken insulin with her out of the facility to administer on her own. She confirmed she was not assessed to be able to give her own insulin. Review of the provider's revised August 2013 Self- Administration of Medications policy revealed an interdisciplinary team would assess the resident's cognitive, physical, and visual ability to self-administer medications.	F 176			
F 223 SS=K	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Surveyor: 32572	F 223	F223 1. Immediate corrective action was taken for Residents 8, 17, 18, 19, 20, 22, 26, 27, 28, 29, 30, 31, and 32 upon discovery/ acceptance of abatement plan on August 12, 2014 and comprehensive plan of correction submitted on August 13, 2014 which included: - Resident 11 was transferred to Hospital Emergency Room for evaluation on August 12th, 2014 at 13:20 MT. Wife transported. - Physician' nurse at Hospital notified at 4:45pm MT by Interim Administrator, of resident not being able to be readmitted to	9-12-14	

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F 223	<p>Continued From page 12</p> <p>Surveyor: 26632 Based on observation, record review, interview, resident group interview, and policy review, the provider failed to ensure one of one sampled resident (11) who wandered and had behavioral symptoms was effectively monitored and had behavioral interventions put in place to ensure no physical or emotional harm occurred to thirteen of thirteen residents (8, 17, 18, 19, 20, 22, 26, 27, 28, 29, 30, 31, and 32).</p> <p>NOTICE: Notice of immediate jeopardy was given verbally to the administrator, the interim administrator, the interim director of nursing, and the director of clinical services on 8/12/14 at 4:25 p.m. They were asked for an immediate plan of correction (POC) at that time. That included: *Monitoring and management of residents with behaviors who wandered. *Assurance of safety and no harm to other residents.</p> <p>PLAN: An immediate POC for resident-to-resident abuse was accepted on 8/12/14 at 7:00 p.m., and the immediate jeopardy was abated (removed). A comprehensive plan of action was accepted on 8/13/14 at 4:10 p.m. That included the following: **Resident 11 would not be readmitted to the provider's care on 8/12/14. Resident 11 was identified on 8/12/14 as a potential safety risk to others. Resident 11 was transferred to the emergency department (ED) on 8/12/14 at 1:20 p.m. The ED physician's nurse was notified at 4:45 p.m. by the interim administrator of resident 11's not being able to be readmitted to this nursing facility because of resident to resident</p>	F 223	<p>this nursing facility r/t resident to resident inappropriate behaviors of a sexual nature.</p> <ul style="list-style-type: none"> - Interim Administrator instructed Emergency Room to fax confirmation of admittance to hospital as soon as possible. - Call placed at 5:15pm MT to Hospital confirmed Resident will be admitted to Behavior unit. - All residents will be reassessed by Interim Administrator, Administrator, Director of Clinical Services, Interim Director of Nursing and Social Services Designee on 8/12/14 &/or 8/13/14 to assure placement is appropriate at facility. Assessment will include review of wandering, behaviors affecting others and danger to self or others. Responsible: Administrator, Interim Administrator, Interim DON - The facility Interim DON or designee will complete Interdisciplinary Progress Note reviews on all progress notes in Point Click Care 5 x /week to identify any potential issues or concerns with resident safety and wellbeing. Responsible: Interim DON or designee - Any issues with residents currently residing at BFHC will be addressed on the date identified, their physician will be involved and the ombudsman as well. The Administrator will report findings to the facility QAPI committee monthly for review and recommendations. - All staff, prior to their next shift worked, from 8/13/14 @ 9am and ongoing, will be educated on the Healthcare Abuse and Neglect Policy and reporting procedures 	

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F 223	Continued From page 13 inappropriate behaviors of a sexual nature. The interim administrator instructed the ED to fax communication of admittance to hospital as soon as possible. A call was placed at 5:15 p.m. by the ED and confirmation was received that resident 11 would be admitted to the hospital at that time." **"All residents would be reassessed by the interim administrator, administrator, director of clinical services, interim DON, and social services designee on 8/12/14 and 8/13/14 to ensure their placement was appropriate. That assessment would include review of wandering, behaviors affecting others, and danger to self or others. The facility interim DON or designee would complete interdisciplinary progress note reviews on all progress notes in Point Click Care (electronic medical record) five times weekly to identify any potential issues or concerns with resident safety and wellbeing. Any issues with residents currently residing at facility would be addressed on the date identified. The resident's physician would be involved and the ombudsman notified as well. The administrator would report findings to the facility quality assurance performance improvement (QAPI) committee monthly for review and recommendations." **"Resident safety, abuse and neglect policy. All staff prior to their next shift worked from 8/13/14 at 9:00 a.m. and ongoing would be educated on the healthcare abuse and neglect policy and reporting procedures. Any issues identified on the education of staff would be taken to the facility QAPI committee monthly by the interim DON or designee for review and recommendations." **"Admission process. The administrator and/or interim administrator and the interim DON or DON would be involved and approve all admissions/readmissions. Any resident admission issues would be compiled and then	F 223	(included in the policy.) Responsible: Interim DON or designee - Any issues identified with the education of associates will be taken to the facility QAPI committee monthly by the Interim DON or designee for review and recommendations. - Administrator and/or Interim Administrator & Interim DON or DON will be involved and approve all admissions / re-admissions to the facility.. Responsible: Administrator and / or interim administrator. - Any resident admission issues will be compiled and then will be brought forward by the Administrator, Interim Administrator and Interim Director of Nursing to the facility QAPI committee monthly for review and recommendations 2. All residents have the potential to be affected. 3. In addition to actions taken and education provided on August 12-13, 2014 (outlined above) the DON will ensure that all staff have been in-serviced NLT September 12, 2014 on the Abuse Policy. A Social Service Consultant will in-service all staff on Resident Rights. Those staff on vacation, sick leave, or casual status will be in-serviced prior to their return to work. 4. The DON or designee will audit to ensure that each allegation of Abuse is		

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F 223	<p>Continued From page 14 brought forward by the administrator, interim administrator, and the interim DON to the facility QAPI committee monthly for review and recommendations."</p> <p>During the extended survey on 8/12/14 at 7:00 p.m. the surveyors confirmed removal of the immediate jeopardy situation. Findings include:</p> <p>1. Review of resident 11's medical record revealed he had been admitted on 5/30/14 from home. He had diagnoses that included Alzheimer's dementia (deteriorated mentally).</p> <p>Review of resident 11's following interdisciplinary progress notes revealed: *A 5/30/14 12:15 p.m. admission note included: -He was admitted from his home. -He had lived with his wife. -His wife stated he had his days and nights mixed up, was very active at night, and he had to use the restroom frequently at night. -A Wanderguard (tracking bracelet) was put on his left wrist as his wife stated he did get up at night and wander. He would not know where he was going. *A late entry on 5/31/14 at 3:01 p.m. "Resident was found outside of the front door sitting in a person's car. The day was about 65-70 degrees Fahrenheit outside. When returning inside he showed no signs of dehydration or injuries. Normal behavior was observed for an individual with dementia and wandering." *A late entry on 5/31/14 at 6:45 p.m. "Resident was sexually inappropriate with CNAs [certified nursing assistant]." *A 6/1/14 at 6:47 p.m. note "Resident was being sexually inappropriate with CNAs."</p>	F 223	<p>reported as required, investigated and plans of care are updated to reduce the likelihood of reoccurrence. Audits will continue weekly for 4 weeks and then monthly. Results of audits will be discussed by the DON at monthly Quality Assurance Process Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>5. September 12, 2014 <i>*for two quarters. KW/SDDH/MF</i></p> <p>X Residents with behaviors that affect others have care plan interventions put into place. Resident's 18, 19, 20, 22, 28, 29, 31 and 32 have had their need for room barrier strips across the door re-evaluated. Staff were educated to report behaviors that affect others (staff, residents, visitors). Audit will include interview with random residents who will be asked if they are fearful of anyone and if they are satisfied with their care and services. Progress notes and Pont of Care documentation will be included in the audit to identify behaviors that require intervention/Abuse Reporting. <i>KW/SDDH/MF</i></p>	

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F 223	<p>Continued From page 15</p> <p>*A 6/2/14 note at 9:11 p.m. "Resident was up wandering and headed outside but was stopped before he made out the doors."</p> <p>*A 6/2/14 at 9:13 p.m. note "Resident was being sexually inappropriate with the CNAs."</p> <p>*A 6/10/14 at 3:46 p.m. Care area assessment [CAA] for resident behaviors "Resident has Alzheimer's and has behavior d/t (due to) this. He wanders around is not aware of his surroundings. He also has been making sexually inappropriate comments to staff. He did wander at home but not sure if he had other behaviors. His behaviors are easily controlled at this time."</p> <p>*A 6/11/14 at 4:19 a.m. note "Resident has been awake most all of shift wandering around building going into other resident's rooms turning on water in bath rooms or lights sitting in chairs in rooms several female residents reported being scared by him."</p> <p>*A 6/24/14 at 5:42 a.m. note "Resident at 2:30 a.m. was found in bed in _____ [room and bed number] with female resident 32. He was removed from the room and directed back to his room where he stayed for most of the night."</p> <p>*A 7/2/14 at 12:30 a.m. note "Resident in room _____ [Resident 30] is yelling @ [at] him to get out and using her walker to direct him out and _____ [resident 27] is attempting to hit him with her pillow and telling him to get away from her, both women very upset, they report they wake up with him standing over them telling them to get up. _____ [resident 11] escord [escorted] out of their room and taken back to his to use the BR [bathroom]."</p> <p>*A 7/13/14 at 4:54 a.m. note "Resident becoming more combative with staff when trying to redirect him out of other's rooms or put clothes on him after he takes them off. Did attempt to leave building 1 time, got as far as between the front</p>	F 223			

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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	
F 223	Continued From page 16 doors before staff turned him around." *A 7/16/14 at 2:14 p.m. activities aide note "I spent a lot of 1 on 1 times with _____ [resident 11] today. He is confused and tends to wander in other residents' rooms which is very upsetting to many of them. He was able to work with wooden blocks and dominoes but needed constant cueing d/t dementia. He did read several items in the newspaper. When he became restless, we offered him the restroom and something to eat/drink, which did calm him down. Did take a short nap in recliner in the activity room before lunch. Visited with the CRAs [certified resident assistant] on 300 wing (where most of our wandering residents are located) and told them to bring these residents to us and we would [provide] activities/supervision as needed." *A 7/27/14 at 5:23 a.m. note "On 7/26/14 at 2145 [9:45 p.m.] resident reached down inside of female CNA's top and tried to fondle her breasts resident was told that this was not allowed and was redirected back to his room and toileted by CNA and male nurse, when done resident then made comment that he would make it all right if she came to bed with him. At 2330 (11:30 p.m. on the same evening resident was found groping female resident's (rm _____) (resident 29) breasts and was informed that this was not allowed at which time he just chuckled and hit the CNA several times. Resident was redirected to a recliner in the open court where he stayed most of the shift." *A 7/30/14 at 5:00 a.m. note "Resident walked up to a female resident [resident not identified in note] and dropped his pants, CNA intervene promptly and escort resident after helping to pull up pants out of the area." *A 8/3/14 at 8:50 p.m. note "Resident in room _____, shaking _____ (resident 22), turning	F 223			

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F 223	Continued From page 17 buttons on resident C-PAP [continuous positive air pressure] machine. Resident 22 was yelling and I went in and attempted to redirect." *A 8/7/14 at 1:30 a.m. note "Was asked to remove resident out of another residents room, when attempt to escort him out he told me to shut up, hit my hand away and slaped [slapped] my mouth. While leaving the area he cont (continued) to tell me to shut up and attempt to hit my mouth and hand several times. Did get to his room and sat on bed, would not lay down and told me to leave. Report off to CRA that were caring for him, they would F/U (follow up) on him." *A 8/8/14 at 2:31 p.m. physician's order note "Resident was seen this afternoon by _____ (physician's name) for 30 day review." There was no mention of resident 11's behaviors or wandering in those physician's note. *A 8/9/14 at 9:30 a.m. note a facsimile had been sent to his physician that included a possible request for some melatonin to assist with his sleep. *A 8/10/14 at 10:45 p.m. note "Resident found in another residents room, attempting to get her up and take him to BR, cursing @ her and tugging on her leg to get up. Resident 22 becoming upset and little scared. Appologis [apologies] as he was being removed from her room. Resident 11 hitting @ staff and telling her to shut up." *A 8/10/14 at 11:00 p.m. note "Resident from room ____ (resident 19) out @ the nurse's station asking for staff to come and remove _____ (resident 11) from her room, he is telling _____ (resident 28) to get up and come with him, he needs to use the toilet and needs 'Mamma's help', resident escorted out and taken to his BR, he is little aggressive tonite and telling staff to leave him alone, shut up and attempting to hit the staff."	F 223			

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F 223	<p>Continued From page 18</p> <p>*A 8/10/14 at 11:30 p.m. note "Resident was in room _____ (resident 22) attempting to get into bed with that resident who was screaming for help. _____ (resident 11) was removed but he was also attempting to hurt staff and call her names."</p> <p>*A 8/11/14 at 12:00 a.m. note "Resident again back into Rm (room) _____ (resident 22), telling her to get up and pulling @ her feet. Her room is dark and he is able to get to her bedside by the window and wake her up. She has request to some how keep him out, she has agree [agreed] to shut her door to see if that will stop him, cont to monitor and appologis for the incident."</p> <p>Review of a 8/11/14 physician's order for resident 11 revealed melatonin three milligrams one capsule by mouth at bedtime for sleep had been ordered.</p> <p>Review of resident 11's care plan revealed: *A revision on 7/29/14 by the MDS coordinator that included: -A focus area for wandering and sexually inappropriate comments and behaviors. -A goal his behaviors would have been addressed as they occurred. -Interventions that included: "I wander and often wander into other resident rooms. Monitor for this and redirect me. Monitor for behaviors and assess for any physical, emotional or social cause and correct if possible." *A 6/17/14 entry by the activity director that included: -A focus area that "Staff must anticipate and provide all of my social needs D/T [due to] Alzheimer's disease." -A goal that "I will attend and participate in planned activities that I enjoy with assistance</p>	F 223		

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F 223	<p>Continued From page 19</p> <p>from staff as needed. I will show acceptance and enjoyment in attending these activities through positive verbalizations and expression each review."</p> <p>-Interventions that included "Staff provide me with 1:1 (one-to-one) visits PRN (as needed). Activity staff provide me with 1:1 time/activities when I am wandering."</p> <p>*A 5/30/14 entry by the social services director (SSD) that included:</p> <p>-A focus area on cognition [memory]. "I am alert and quiet, I am able to converse minimally and make limited decisions. My wife will be my major decision maker and will attend my care conference."</p> <p>-A goal of "I want to maintain my alert cognitive status. I would like to participate in the decision making I am able to do such as leaving my room, going to the bathroom etc. with staff assistance for guidance."</p> <p>-Intervention of "I want staff to monitor for changs [changes] in my cognition, such as worsening, or inability to determine what I want. Staff will anticipate decision making and report any noticeable changes to nursing."</p> <p>Review of the behavior charting for resident 11 from 6/8/14 through 6/16/14 by the CRAs revealed:</p> <p>*He had wandering on 6/8/14 at 1:02 a.m. and 8:49 a.m., and on 6/11/14 at 10:52 p.m. that did not impact other residents.</p> <p>*He had wandering on 6/8/14 at 3:15 p.m. and 11:40 p.m., 6/9/14 at 10:51 p.m., 6/10/14 at 5:28 a.m. and 2:19 p.m., 6/11/14 at 3:06 a.m., 6/14/14 at 5:37 a.m., 12:18 p.m., and 9:29 p.m., 6/15/14 at 5:54 a.m., 10:18 a.m., 3:12 p.m., and 11:54 p.m., and 6/16/14 at 9:31 a.m. that significantly intruded on other residents' privacy or activities.</p>	F 223			

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F 223	<p>Continued From page 20</p> <p>*On 6/12/14 at 5:35 a.m. he had repetitive verbalizations that caused a disruption of the care or living environment and significantly intruded on other residents' privacy or activities.</p> <p>*On 6/13/14 at 10:25 a.m. he had repetitive verbalizations that interfered with his care.</p> <p>Review of resident 11's 6/8/14 admission MDS, section E (behaviors), revealed:</p> <p>*He had no indications of hallucinations or delusions that would have indicated psychosis (altered state of mind).</p> <p>*He had behavioral symptoms that included verbal behavioral symptoms directed toward others (for example threatening others, screaming at others, and cursing at others). Behaviors of that type had occurred one to three days during the seven day assessment reference period.</p> <p>*That behavioral symptom impacted the resident for physical illness or injury, significantly interfered with his care, or significantly interfered with his participation in activities or social interactions.</p> <p>*That behavioral symptom did not put other residents' at a significant risk for physical injury, significantly intrude on the privacy or activity of other residents', or significantly disrupt care or the living environment.</p> <p>*He had no rejection of care behaviors.</p> <p>*He had wandered one to three days during the seven day assessment reference period.</p> <p>*His wandering did place the resident at a significant risk of getting to a potentially dangerous place (for example outside of the building.)</p> <p>*His wandering did significantly intrude on the privacy or activities of other residents'.</p>	F 223		

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F 223	<p>Continued From page 21</p> <p>Surveyor: 20031 Resident group interview on 7/29/14 at 3:05 p.m. revealed five of eleven residents (8, 17, 18, 19, and 26) voiced concerns about incidents at the facility. They were in agreement about two residents (1 and 11) who would wandered throughout the facility and enter other residents' rooms without permission. They stated they were not concerned about resident 1 as she was confused and did not cause any harm. They did express concerns about resident 11, as he would not leave the female resident's rooms. Residents 18 and 19 revealed they had asked the staff to place a barrier on their doors to try and prevent resident 11 from entering their rooms. They stated they would call for staff and they would come and take him out of the room, but he would come right back.</p> <p>Surveyor: 26632. Observation on 8/12/14 at 9:20 a.m. revealed wide yellow plastic banners had been placed across the entrances to residents 18, 19, 20, 22, 28, 29, 31, and 32's rooms.</p> <p>Interview on 8/12/14 at 9:22 a.m. with resident 20 revealed he was not sure when the yellow banner had been placed across the entrance to his door. He stated there was another resident who frequently entered his room. He also stated he fell a lot. By having the banner across his door, his door could stay open, and he would not fall as much. He wanted his door closed due to another resident that wandered frequently into his room.</p> <p>Interview on 8/12/14 at 9:30 a.m. with the interim DON/MDS coordinator revealed residents would ask her or the social services designee (SSD) for a barrier to be put up across the entrance to their</p>	F 223		

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F 223	<p>Continued From page 22 doors if needed.</p> <p>Interview on 8/12/14 at 9:45 a.m. and at 1:20 p.m. with resident 19 revealed the yellow plastic banner had been put up across the entrance to her and her roommates (resident 28) door the previous evening (8/11/14). She stated she had requested that as resident 11 had been coming into their room. She stated she was not afraid of him. But she was worried about her roommate, as she was very "vulnerable" and he had "messed" with her (resident 28) before.</p> <p>Interview on 8/12/14 at 10:25 a.m. with the SSD regarding resident 11 revealed: *They had placed yellow banners across the entrances to rooms he frequently entered. *She agreed four of the seven yellow banners had just been placed on 8/11/14 and the morning of 8/12/14. *She had visited with resident 11's wife approximately ten days ago regarding his behaviors. *She stated resident 11's wife had told her he had the same behaviors when he was at home. *She had not documented that conversation.</p> <p>Review of resident's 18, 19, 20, 28, 29, 31, and 32's interdisciplinary progress notes revealed no documentation of when the yellow plastic banners had been placed across the entrances to their rooms. Resident 22 had documentation she had asked for a room banner on 8/12/14 at 9:30 a.m.</p> <p>Interview on 8/12/14 at 12:55 p.m. with the interim DON/MDS coordinator regarding resident 11 revealed: *No behavioral interventions had been put in place in regards to his wandering and</p>	F 223		
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F 223	<p>Continued From page 23</p> <p>inappropriate sexual behaviors.</p> <p>*Redirection did not work anymore for his behaviors.</p> <p>*She had not known until 8/10/14 he had been putting his hands down the CNAs shirts. Staff had told her while she was the charge nurse he had been doing that for awhile.</p> <p>*She agreed there was no documentation of resident 11's physician or wife having been contacted regarding his behaviors.</p> <p>Surveyor: 32572</p> <p>Interview on 8/12/14 at 1:20 p.m. with resident 27 confirmed she had been slapped on the face by a male resident when trying to assist him out of her room. She was unable to tell this surveyor the name of that resident. She stated "He calls out for Mama." She confirmed she was afraid of him because of that physical abuse. The majority of his wandering occurred at night.</p> <p>Interview on 8/12/14 at 1:37 p.m. with resident 22 confirmed she had been "bothered" by a male resident who wandered into her room since she had been a resident within the facility. She was able to tell this surveyor that this specific male resident had a diagnosis of dementia (deteriorated mental status). That male resident had hit her, and she had reported the physical abuse to a staff member. She was unable to tell this surveyor who the staff member was. That wandering resident had caused disruption in her sleep patterns. She gave an example of the prior night, when that resident had awakened her at 10:00 p.m., 11:30 p.m., and midnight. She had turned her call light on and had staff remove him from her room.</p> <p>Surveyor: 26632</p>	F 223			

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F 223	<p>Continued From page 24</p> <p>Review of an 8/12/14 unsigned, untimed facsimile to resident 11's physician revealed: **Resident has behaviors, wandering, sexually assaulting residents & [and] staff & physically abusing staff. *The physician's response was "Send to _____ (hospital name) ER (emergency room) for evaluation & possible admission to behavior management due to behaviors."</p> <p>Review of the 7/1/14 physician's progress notes for resident 11 revealed the staff had reported there were no behavioral changes.</p> <p>Review of the South Dakota Department of Health required nursing facility event reports regarding resident 11 included: *On 7/26/14 he had been reported to have groped a female resident's breasts. -The plan was to have been "Will visit with resident's physician and wife about possible interventions and it will become part of his care plan that he needs to be monitored and away from female resident's." *On 8/10/14 and 8/11/14 he had been reported to have cursed and attempted to get in bed with a female resident. -On 8/11/14 "Yellow banners across the doors are now on 309, 310, as well as 320 and 313 and 318 and this has turned _____ (resident 11's name) from those rooms." -His care plan had not been updated after the 7/26/14 incident to include the monitoring. -There was no documentation resident 11's physician or wife had been consulted regarding his behavior.</p> <p>Review of the provider's revised February 2014 Behavior Assessment and Monitoring policy</p>	F 223		

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F 223	Continued From page 25 revealed: *Problematic behavior would be identified and managed appropriately. *The nursing staff would identify, document, and inform the physician about an individual's mental status, behavior, and cognition including the onset, duration, and frequency of problematic behaviors or changes in behavior. Review of the provider's June 2013 Behavioral and Mental Health Treatment policy included: *All residents with behaviors against other residents would have an in person assessment to ensure those behaviors were able to be managed. *Any resident who displayed an outburst of unmanageable behavior which places other residents at risk would have been sent by ambulance to the ER.	F 223			
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Surveyor: 26632 Based on record review, interview, and policy review, the provider failed to investigate and report to the South Dakota Department of Health (SD DOH) five of seven events of	F 226	F226 1. No immediate corrective action could be taken for Residents 22, 27 and 30. Resident 11 no longer resides in the facility. 2. All residents have the potential to be affected. 3. In addition to actions taken and education provided on August 12-13, 2014 (outlined above in F223) the Director of Clinical Services will ensure that all staff have been in-serviced NLT September 12, 2014 on the Abuse Policy (including reporting requirements). Those staff on vacation, sick leave, or casual	9-12-14	

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F 226	<p>Continued From page 26</p> <p>resident-to-resident abuse for three of three residents (22, 27 and 30) Findings include:</p> <p>1. Review of resident 11's interdisciplinary progress notes revealed: *A 6/11/14 at 4:19 a.m. note "Resident has been awake most all of shift wandering around building going into other resident's rooms turning on water in bath rooms or lights sitting in chairs in rooms several female residents reported being scared by him." *A 6/24/14 at 5:42 a.m. note "Resident at 2:30 a.m. was found in bed in _____ [room and bed number] with female resident. He was removed from the room and directed back to his room where he stayed for most of the night." *A 7/2/14 at 12:30 a.m. note "Resident in room _____ (Resident 30) is yelling @ (at) him to get out and using her walker to direct him out and _____ (resident 27) is attempting to hit him with her pillow and telling him to get away from her, both women very upset, the report they wake up with him standing over them telling them to get up. _____ (resident 11) escort (escorted) out of their room and taken back to his to use the BR (bathroom)." *A 7/30/14 at 5:00 a.m. note "Resident walked up to a female resident (resident not identified in note) and dropped his pants, CNA (certified nursing assistant) intervene promptly and escort resident after helping to pull up pants out of the area." *A 8/3/14 at 8:50 p.m. note "Resident in room _____, shaking _____ (resident 22), turning buttons on resident C-PAP (continuous positive air pressure) machine. Resident 22 was yelling and I went in and attempted to redirect." Review of the provider's allegations of abuse files</p>	F 226	<p>status will be in-serviced prior to their return to work.</p> <p>4. The DON or designee will audit to ensure that each allegation of Abuse is reported as required, investigated and plans of care are updated to reduce the likelihood of reoccurrence. Audits will continue weekly for 4 weeks and then monthly. Results of audits will be discussed by the DON at monthly Quality Assurance Process Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>5. September 12, 2014 <i>*for two quarters. KWISDOHME</i></p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2014
NAME OF PROVIDER OR SUPPLIER BELLE FOURCHE HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 13TH AVE BELLE FOURCHE, SD 57717		
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F 226	<p>Continued From page 27</p> <p>for the previous six months revealed none of the above incidents had been investigated, reported to the SD DOH, or corrective action taken.</p> <p>Review of the provider's undated Abuse Prevention Plan policy revealed: *The provider required all suspected maltreatment would be reported to the SD DOH promptly. *All staff were required to report suspected mistreatment of a vulnerable adult to the administrator and the director of nursing (DON). If the administrator and DON were not in the building report to the nursing supervisor at the time of suspicion. *The administrator, DON, or nursing supervisor would make sure a report was made out and the internal investigation began immediately. The appropriate reporting would take place, and interventions would be implemented to provide the vulnerable adult with a safe living environment. *All resident-to-resident incidents, unless isolated and resulted in no actual harm, must be report to the SD DOH. *The administrator was ultimately in charge of the Abuse Prohibition plan and was to have been informed of all incidents and internal investigations immediately not to exceed twenty-four hours. In the case of the administrator was unavailable the designee would be notified in that timeframe.</p> <p>Surveyor: 32572 Interview on 7/30/14 at 2:40 p.m. with the social service designee (SSD) revealed: *She was the staff member who was responsible for the coordination of the abuse prevention policies.</p>	F 226		

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F 226	Continued From page 28	F 226			
F 250 SS=E	<p>*Residents who wandered were at the highest risk and they were monitored more closely.</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162</p> <p>Surveyor: 26632 A. Based on record review, interview, policy review, and job description review, the provider failed to ensure: *Medically necessary social services had been put in place to intervene and advocate for one of one sampled resident (11) who was experiencing sexually inappropriate and aggressive behaviors and was potentially at risk for harm to others. *Five of eleven (1, 5, 17, 18, and 19) residents who participated in the group interview were invited to attend their regularly scheduled care conference (meeting). Findings include:</p> <p>1. Review of the provider's revised 10/31/11 Social Services Director (SSD) job description revealed the following responsibilities: **Reported to the administrator." **As a member of the interdisciplinary care team was responsible for ensuring that the residents</p>	F 250	<p>F250</p> <p>1. Resident 11 was sent to the hospital for evaluation and was subsequently admitted. No immediate corrective action could be taken for Residents 1, 5, 17, 18 and 19.</p> <p>2. All residents have the potential to be affected.</p> <p>3. The Social Service Director has been in-serviced by the Director of Clinical Services on the following: The requirement to invite residents to their care plan meeting, the Grievance Policy and reviewed the Social Services Job Description and Policy.</p> <p>4. The Administrator or designee will audit all scheduled care conferences each week to ensure the resident has been extended an invitation and audit all grievances to ensure all grievance include resolution and residents are informed of such. A Social Service Consultant will review resident interventions put into place by the Social Service Director and provide recommendations weekly for 4 weeks and then quarterly thereafter. Audits for care conferences and grievances will continue weekly for 4 weeks and then monthly. Results of audits will be discussed by the Administrator at monthly Quality</p> <p><i>*for two quarters. KNOX/DH/ME</i></p>	9-12-14	

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F 250	<p>Continued From page 29</p> <p>social and emotional needs were met as established in the residents bill of rights." **Screened and coordinated admissions and discharges." **Ensured assessments and other identified forms within the resident assessment instrument process were completed within a timely manner. Participated in care plan meetings, developed and documented care plan problems and assisted the interdisciplinary team in completing the Minimum Data Set [comprehensive resident assessment]." **Responded promptly and professionally to addressing requests, problems, or concerns." **"Was knowledgeable of residents and their needs." **Demonstrated competent performance of assessment skills with appropriate follow through and documentation." **Identified subtle changes in resident activity levels." **Proactive in monitoring areas that may affect resident care."</p> <p>Review of the provider's March 2014 The Role of the Social Worker in Long Term Care policy revealed: **The social worker (SW) would be responsible for prompt, accurate, and efficient social assessment and care planning." **Progress notes would be current and accurate." **The SW would be involved in the resident admission process and would coordinate the discharge planning for each resident." **The SW would respond immediately resident issues that included resident requests and complaints. Documentation would reflect involvement." **The SW would be responsible to work with each</p>	F 250	<p>Assurance Process Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>5. September 12, 2014</p> <p><i>* The Social Services Consultant will review all of the SSDs IPNS each week for four weeks. Those residents with behaviors will have their plan of care reviewed each week for four weeks. KW/SD/DCH/MF</i></p>		

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F 250	<p>Continued From page 30</p> <p>resident ensure adjustment to the facility was achieved by addressing individual needs which may have included environment, roommate, schedules, etc."</p> <p>*"The SW would provide one-to-one visits as indicated and documentation would reflect involvement."</p> <p>*"The SW would be involved in any residents' use of psychoactive medications, would review and monitor along with nursing staff and assist with non-medication interventions."</p> <p>Group interview on 7/29/14 at 3:05 p.m. with eleven randomly selected residents revealed five residents (1, 5, 17, 18, and 19) stated they had not been invited to their nursing care conference. All five of those residents were unaware a meeting for their individualized plan of care took place on a regularly scheduled basis. Refer to F151.</p> <p>Interview on 8/12/14 at 10:25 a.m. with the SSD regarding resident 11 revealed: *They had placed yellow banners across the entrances to residents' rooms he frequently entered. *She agreed four of the seven yellow banners had just been placed on 8/11/14 and the morning of 8/12/14. *She had visited with resident 11's wife approximately ten days ago regarding his behaviors. *She stated resident 11's wife had told her he had the same behaviors when he had been at home. *She had not documented that conversation. Refer to F223, finding 1.</p> <p>Interview on 7/30/14 at 2:40 p.m. with the SSD revealed:</p>	F 250		

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F 250	Continued From page 31 *She was the staff member who was responsible for the coordination of the abuse prevention policies. *Residents who wandered were at the highest risk and they were monitored more closely. Refer to F226, finding 1. B. Based on document review, group and staff interview, and policy review the provider failed to inform twelve of twelve (1, 5, 7, 17, 18, 19, 20, 21, 23, 24, 25, and 26) residents of any resolution to the resident council grievances and/or individual resident or visitor concerns for the previous and current eight months (January 2014 through August 2014). Findings include:	F 250			
F 253 SS=B	1. Refer to F166. 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to: *Maintain one of one poker table surfaces free of spilled food and drink debris. *Ensure paper hygiene products, chemicals, and cleaners were not stored together in three of four areas (200 and 300 wing storage rooms and the 400 wing housekeeping cart). *Maintain clean lint filters and the surrounding bin areas for two of two commercial dryers.	F 253	F253 1. The poker table has been cleaned; paper hygiene products, chemicals and cleaners are not stored together in storage rooms or housekeeping carts; the lint filters have been cleaned; the shelving unit in the tub room has been replaced; and the clean linens are being stored properly. 2. All residents have the potential to be affected. 3. The Administrator will in-service all staff NLT September 12, 2014 on the following: Maintaining and cleaning our furniture; Maintaining cleanable surfaces; Separation of supplies and chemicals when stored; cleaning of the lint filters; and proper storage of clean linens. Those	9-12-14	

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F 253	Continued From page 32 *Maintain a cleanable surface for one of one plastic shelving unit in the 200 wing residents' tub room. *Store clean linens in a cleanable non-absorbent container in one of two tub rooms (200 wing). Findings include: Surveyor: 23059 1. Observation on 7/29/14 at 8:00 a.m. revealed the poker table in the front bistro area (activity and snack area) had been heavily soiled. There were what appeared to be cake crumbs, cookie crumbs, spilled drinks, frosting on the vinyl covered top and edges, and other unidentified splatters and debris. The dried and layered debris could not be scraped or chipped free with a fingernail. The particles of debris could be swept with a hand into a small pile. The felt poker chip holders also had a layer of debris in the bottom that resembled the debris on the table. Observation on the same day at 11:25 a.m. revealed that poker table had not yet been cleaned (photos 3 and 4). Interview on 7/29/14 at 11:30 a.m. with the activities director revealed the poker table was seldom used. She stated she thought it might have been used on 7/27/14 for poker games. She stated the table was to have been cleaned after each use. She confirmed the felt chip holders were difficult to clean. She stated the activities staff were responsible for cleaning the table. She confirmed it was heavily soiled at that time. Surveyor: 20031 2. Observation on 8/13/14 from 8:15 a.m. to 9:45 a.m. revealed: a. The housekeeping closets in the 200 and 300 wing, and the 400 wing housekeeping cart had toilet paper and paper towels stored together with	F 253	staff on vacation, sick leave, or casual status will be in-serviced prior to their return to work. 4. The Administrator or designee will do walking rounds in the facility weekly to ensure: furniture is clean and in good repair with cleanable surfaces; lint filters are clean; supplies, chemicals and linens are stored properly. Audits will continue weekly for 4 weeks and then monthly. Results of audits will be discussed by the Administrator at monthly Quality Assurance Process Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audit. 5. September 12, 2014 <i>x for two quarters. kw/sdd/hmf</i> <i>* Staff have been educated on reporting equipment/furniture that are in need of repair and what constitutes a "clean surface." A daily checklist has been implemented on each dryer to ensure daily cleaning of lint traps. kw/sdd/hmf</i>	

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F 253	Continued From page 33 cleaners and chemicals. Interview with the director of plant operations (DPO) at the time of the observation confirmed those findings. He revealed staff were aware paper hygiene products could not be stored next to or with cleaners and/or chemicals. b. The two commercial dryers had layers of lint on the mesh screen filter and had not been completely cleaned of lint. One black mesh screen appeared to be covered with a blanket of white from the lint. Large dust balls the size of footballs and baseballs laid in the area surrounding both dryers. Interview with the DPO at the time of the observation confirmed those findings. He stated he had thought staff cleaned the dryers daily. He stated he had no policy or duty sheet for the staff to use for cleaning of those dryers. c. The three tiered plastic shelf in the 200 wing residents' tub room had a pink curtain taped to the top of the unit (photo 5). Interview with the DPO at the time of the observation confirmed that finding. He agreed the tape along the top of the shelving unit created an uncleanable surface. d. Clean towels were stored in a cardboard box in the 200 wing tub room. That cardboard box was not a cleanable and was not the original container. (photo 6) Interview with the DPO at the time of the observation confirmed that finding.	F 253		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	F280 1. Resident 1, 4, 6, 8 and 10's care plan has been updated to reflect their current care needs. 2. All residents have the potential to be affected.	9-12-14

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F 280	<p>Continued From page 34</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review, interview, observation, and policy review, the provider failed to review and revise care plans to reflect the resident's current condition for five of thirteen sampled residents (1, 4, 6, 8, and 10.). Findings include:</p> <p>1. Review of resident 1's medical record revealed: *Nursing progress notes on 1/22/14 stated a pressure ulcer had been identified. *Her last revised 3/29/14 care plan had an intervention dated 2/19/14 for a pressure ulcer on her left heel. Nursing was to have provided daily treatment and wound care to the pressure ulcer. *Her care plan had not been updated to reflect the current status of her pressure ulcer, the wound care, and other wound interventions that were noted within her medical record.</p> <p>Surveyor: 26632</p>	F 280	<p>3. The DON will in-service all staff NLT September 12, 2014 on care plan implementation, updating care plans, and ensuring interventions are in place. Those staff on vacation, sick leave, or casual status will be in-serviced prior to their return to work.</p> <p>4. The DON or designee will check 4 random care plans each week to ensure the plan of care matches the resident's care needs.. Audits will continue weekly for 4 weeks and then monthly. Results of audits will be discussed by the DON at monthly Quality Assurance Process Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>5. September 12, 2014 <i>x for two quarters. xw/cdch/mf</i></p>	

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F 280	<p>Continued From page 35</p> <p>2. Review of resident 4's medical record revealed: *He had been admitted on 7/23/14. *He had been admitted to hospice care on 7/24/14. *His admission physician's orders indicated he was on a 1000 milliliter (ml) daily fluid restriction. *He had a stage 2 pressure ulcer (partial thickness loss of dermis [skin] presenting as a shallow open ulcer with a red pink wound bed, without slough [dead tissue]. May also present as an intact or open/ruptured serum [fluid]-filled blister. to his right buttock (right side of bottom). *On 7/25/14 a urinary catheter had been inserted. *He had acquired a second stage 2 pressure ulcer to his coccyx (tailbone) on 7/28/14.</p> <p>Observation of resident 4 on 7/29/14 at 8:30 a.m., 12:30 p.m., 2:45 p.m., 4:00 p.m., from 4:59 p.m. through 5:29 p.m., and at 6:20 p.m. revealed: *He was seated in his recliner. *He had no cushion under him. *There was no cushion in his wheelchair. *He had a urinary catheter.</p> <p>Interview on 7/29/14 at 2:45 p.m. with resident 4 revealed he: *Had eaten in the dining room one time since his admission. *Got too tired to wait in the dining room for meals, so he now ate his meals in his room. *Was in his recliner or wheelchair from when he got out of bed for breakfast until he went to bed around 8:00 p.m. *Was never offered by staff to lay down in his bed during the day. *Did not understand why he had a fluid restriction.</p> <p>Review of his 7/23/14 immediate plan of care</p>	F 280	<p>* In addition to random care plan audits, The DON will audit all new admissions to ensure an immediate care guide is implemented upon admission and then will ensure comprehensive care plan is developed by Day 21 and is inclusive of resident's care needs and that any allergies are entered into the resident allergy list. Those residents with fluid restrictions will be identified on the Treatment Record and will include how much fluid is to be provided by nursing and dietary each day. Res 4's TAR has been updated. Allergies have been included on the allergy list for Res 8. In addition to all new admissions, the DON or designee will audit four random medical records to ensure allergies are entered into the resident allergy list. Audits will be weekly for four weeks and then monthly X5 months.</p> <p style="text-align: right;">KW/SDDH/MF</p>	

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F 280	<p>Continued From page 36 upon admission revealed:</p> <ul style="list-style-type: none"> *He was on hospice care. *He ate his meals in the main dining room during the second seating. *He was continent of urine, used a urinal, and also used an incontinent brief. *Had a stage 2 pressure ulcer to his right buttock. *Had a low loss air mattress on his bed. *Was to have been turned every two hours when in bed. *There was no information on his repositioning while in his recliner or wheelchair. *There was no information on his urinary catheter. *There was no documentation of how much fluid he was to have received from nursing or dietary departments. <p>Surveyor: 32572</p> <p>3. Review of resident 8's 4/23/14 revised care plan indicated an allergy to carisoprodol (muscle relaxant) and ciprofloxin (antibiotic).</p> <ul style="list-style-type: none"> *Review of her 5/29/14 electronic prescription received from the clinic revealed allergies of "Baclofen (muscle relaxant), carisoprodol (muscle relaxant), Cipro (antibiotic), cyclobenzaprine (anti-rejection medication), Skelaxin (pain medication), Soma (muscle relaxant), and muscle relaxants." *Review of the 7/1/14 signed physician's orders revealed allergies of carisoprodol and ciprofloxin. *Review of the July 2014 medication administration record (MAR) indicated an allergy to carisoprodol and ciprofloxin. *The care plan, current physician's order, and MAR did not reflect the allergies listed from the physician's office from the electronic prescription that had been obtained on 5/29/14. 	F 280		
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F 280	<p>Continued From page 37</p> <p>Interview on 7/31/14 at 9:07 a.m. with the interim administrator confirmed she would have expected all allergies to have been included in the medical record. She would have expected when a new allergy had been noted nurses would have added them to the allergy list.</p> <p>Review of the provider's revised June 2013 Resident Allergy policy revealed "Any new allergies during the resident stay will be added to the resident allergy list and shared with the ID (interdepartmental) team."</p> <p>4. Review of resident 6's 1/22/14 revised care plan indicated she was at risk for skin breakdown with a current pressure ulcer to her right heel. Observation on 7/29/14 at 3:50 p.m. revealed that pressure ulcer had been present at that time. *The goal had been to assess her skin routinely and she "Will have no skin breakdown through the review date of 8/29/14." *That care plan indicated conflicting information, as it did not have the pressure ulcer to the right heel on it. *Refer to F314, finding 5.</p> <p>5. Review of resident 10's 5/23/14 revised care plan indicated he was at risk for skin breakdown. There had been no indication of a current open area to his right inner ankle on his current care plan. *Refer to F314, finding 6.</p> <p>Surveyor 29162</p> <p>6. Interview on 8/12/14 at 10:45 a.m. with the interim director of nursing revealed care plans were to have been updated as resident's condition and needs changed. She agreed that had not been the current practice. She stated the</p>	F 280		

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F 280	Continued From page 38 care plans usually were updated with care conferences. Review of the provider's last updated April 2013 "Care Planning IDT [interdepartmental team]" policy revealed the care plan was: **"To assure the resident attains or maintains their highest practicable physical, mental, and psychosocial well being." **"To be reviewed and updated as needed."	F 280			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review and interview, the provider failed to ensure one of ten sampled residents (13) who required transfer and toileting assistance was assisted in a timely manner and remained free from skin injury. Findings include: 1. Review of resident 13's 8/1/14 at 10:23 a.m. progress notes revealed the following: **Resident was left in the restroom unattended for approx. [approximately] 45 minutes. upon assessment on RT [right] upper thigh next to the RT gluteal [bottom] fold a open area has appeared approx. 1 inch long 1/2 cm [centimeter]	F 309	F309 1. No immediate correction could be made for Resident 13. 2. All residents who require assistance with toileting/transfer have the potential to be affected. 3. The DON will in-service all nursing staff NLT September 12, 2014 on toileting and transferring so that skin breakdown is avoided. Those staff on vacation, sick leave, or casual status will be in-serviced prior to their return to work. 4. The DON or designee will check 4 residents who require assistance toileting to ensure they are toileted and transferred per plan of care and assisted promptly to prevent skin breakdown. Audits will continue weekly for 4 weeks and then monthly. Results of audits will be discussed by the DON at monthly Quality Assurance Process Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audit. 5. September 12, 2014 <i>x for two quarters. KW/SDDH/ME</i>	9-12-14	

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F 309	Continued From page 39 wide." *Review of resident 13's medical record revealed no prior open area to her right gluteal fold. Interview on 8/12/14 at 10:50 a.m. with the interim director of nurses confirmed and revealed: *The above resident used a lift to transfer. *There had been no reason she should have been left on the toilet that long. *The above resident had been harmed by the skin injury from the above incident. A policy had been requested from the interim director of nursing regarding resident toileting. That policy had not been received by the time of exit on 8/13/14.	F 309	* Staff were educated on proper sling and mechanical lift use. Neglect was defined. Education was provided on timely call light response. Call light response time will be audited at four random times each day four times weekly for four weeks then monthly x 5 months. KW/SDD/MLM		
F 314 SS=K	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, record review, interview, policy review, and professional standards review, the provider failed to ensure six of eight sampled residents (1, 3, 4, 6, 10, and 13) with acquired (developed at the facility) pressure ulcers (a	F 314	F314 1. Residents 1, 3, 4, 6, 10 and 13 have been assessed by a wound care certified nurse upon discovery and weekly thereafter with changes in treatment and interventions updated as necessary. This was completed on 7/30/14 upon discovery of the deficient practice and acceptance of the immediate plan of correction which included the following: - Effective immediately (7-30-14 at 6:30pm MT) the process owner for Wound Care (LPN) is being replaced by (Registered Nurse). Process Owner: Interim Administrator. Interim Administrator will report to the facility QAPI monthly on the process for further review and recommendation.	9-12-14	

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F 314	<p>Continued From page 40</p> <p>wound that form whenever prolonged pressure occurs) had appropriate interventions and treatments that would have made those acquired pressure ulcers avoidable. Findings include:</p> <p>NOTICE: Notice of immediate jeopardy was given verbally to the interim administrator, director of nursing services (DNS), and the director of clinical services (DCS) on 7/30/14 at 5:28 p.m. They were asked for an immediate plan of correction to ensure all residents at risk of harm from pressure ulcers were effectively assessed and appropriate treatment was put in place.</p> <p>PLAN: An immediate plan of correction for pressure ulcers was accepted on 7/30/14 at 6:30 p.m. from the interim administrator. The plan was as follows: *Task: Wound care nurse and job description. -Person(s) accountable: DCS/DNS. -Root cause analysis: Issues noted w/(with) wound assessment and dressing change. -Goal/plan: Change associate [staff] duties effective 7/30/14. -Action steps: Effective immediately (7/30/14 at 6:30 p.m.) the process owner for wound care [licensed practical nurse (LPN) C] is being replaced by [registered nurse (RN) I.] -Process owner: Interim administrator will report to the facility quality assurance performance improvement (QAPI) monthly on the process for further review and recommendation. -Follow-up: Nurse has reviewed and signed the job description as of 7/30/14. *Task: Wound care nurse assessment and physician orders. -Person(s) accountable: Wound care nurse.</p>	F 314	<p>- Certified Wound Care Nurse, will assess every acquired and admitted pressure ulcer to ensure the staging and length/width/depth is appropriately documented. They will review the physician orders to ensure appropriateness. If the order needs to be modified, they will obtain an order from the physician. The treatment will correspond with the physician orders. They will ensure the interventions are appropriate. Process Owner: Facility wound care nurse. Wound care assessments and Dr orders will be reported to the facility QAPI meeting by the facility DON or designee monthly for further review and recommendation. -Interim Administrator and DON contacted the Medical Director at 6:15pm on 7-30-14. Discussed pressure ulcer IJ and action steps, and QA process. She will be at the facility at 9:00am on 7-31-14 to meet w/ the survey team and facility DNS, Director of Clinical Services and interim Administrator. Process owner: Interim Administrator. Interim Administrator will report any facility skin issues to the facility QAPI meeting monthly PRN All staff will be educated by the DON or designee on which residents currently have a pressure ulcer and what care and treatments are in place for that resident / Also presented includes a presentation on "skin and the elderly" which includes risk factors, prevention and staging of pressure ulcers. All on-coming staff will receive the education prior to working their shift.</p>	

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F 314	<p>Continued From page 41</p> <p>-Root cause analysis: Issues noted with competency</p> <p>-Goal/plan: 7/30/14 and ongoing.</p> <p>-Action steps: RN I and RN/wound care certified (WCC) I will assess every acquired and admitted pressure ulcer to ensure the staging and length/width/depth is appropriately documented.</p> <p>--They will review the physician orders to ensure appropriateness.</p> <p>--If the order needs to be modified, they will obtain an order from the physician.</p> <p>--The treatment will correspond with the physician orders.</p> <p>--They will ensure the interventions are appropriate.</p> <p>-Process owner: Facility wound care nurse. Wound care assessments and Dr. [doctor] orders will be reported to the facility QAPI meeting by the facility DON [director of nursing] or designee monthly for further review and recommendation.</p> <p>*Task: Communication to medical director.</p> <p>-Person(s) accountable: DNS and interim ED [executive director].</p> <p>-Root cause analysis: Update with survey issues.</p> <p>-Goal/plan: 7/31/14 and ongoing.</p> <p>-Action steps: Interim administrator and DON contacted the medical director at 6:15 p.m. on 7/30/14.</p> <p>--Discussed pressure ulcer IJ (immediate jeopardy) and actions steps and QA process.</p> <p>--She will be at the facility at 9:00 a.m. on 7/31/14 to meet w/ the survey team and facility DNS, director of clinical services, and interim administrator.</p> <p>-Process owner: Interim administrator will report any facility skin issues to the facility QAPI meeting monthly PRN [as needed].</p> <p>*Task: Education.</p> <p>-Person(s) accountable: ED/ DNS.</p>	F 314	<p>Process Owner: Director of Nursing. Director of Nursing or designee will report to the facility QAPI meeting monthly on the education process r/t pressure ulcers for further review and recommendation.</p> <p>- All residents will receive a comprehensive skin assessment within the next week by a licensed nurse. Audit will include review of the skin assessment process. Process Owner: Director of Nursing or designee will report weekly skin assessments to the facility QAPI meeting monthly for review and recommendations.</p> <p>- All residents with an acquired and admitted pressure ulcer will be audited daily by the DON or designee to ensure proper interventions are in place. Audit will include questioning staff to ensure knowledge of wound and interventions, and hands-on observations of cares. Audit will include turning and repositioning and observation of cushions and mattresses. Pain management with PU will also be included in the audit. Weekly skin assessments will also be audited and documented. Process Owner: Director of Nursing.</p> <p>- Results of the written audits will be reported weekly by the DON to the interim Administrator. Further review will occur monthly at the facility QAPI meeting for further review and recommendations.</p> <p>- All residents with current skin breakdown or identified at risk (per Braden Scale) will have interventions in</p>	
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F 314	Continued From page 42 -Root cause analysis: Issues noted during survey process with associates and their knowledge of who has skin breakdown. -Goal/plan: Ongoing starting 7/30/14. -Action steps: All staff will be educated by the DON or designee on which residents currently have a pressure ulcer and what care and treatments are in place for that resident. --Also presented includes a presentation on "Skin and the elderly" which includes risk factors, prevention and staging of pressure ulcers. --All on-coming staff will receive the education prior to working their shift. -Process owner: DON or designee will report to the facility QAPI meeting monthly on the education process r/t [related to] pressure ulcers for further review and recommendation. *Task: Identification of skin concerns. -Person(s) accountable: Wound care nurse, charge nurse, and unit manager. -Goal/plan: 8/8/14. -Action steps: All residents will receive a comprehensive skin assessment within the next week by a licensed nurse. Audit will include review of the skin assessment process. -Process owner: DON or designee will report weekly skin assessments to the facility QAPI meeting monthly for review and recommendations. *Task: Audit of pressure ulcers. -Person(s) accountable: Nurse manager. -Root cause analysis: Issues identified with PU [pressure ulcer] systems. -Goal/plan: Daily. -Action steps: All residents with acquired and/or admitted pressure ulcers will be audited daily by the DON or designee to ensure proper interventions are in place. --Audit will include questioning of staff to ensure	F 314	place to prevent further breakdown and healing of current skin issue. ie: mattress, cushion, turning and repositioning schedule, dietary considerations, etc. Licensed associates will be responsible to assure cushion placement is appropriate at time of placement. Process Owner: Director of Nursing. Director of Nursing or designee will report monthly to the facility QAPI meeting on issues noted with prevention of pressure ulcers. - All families or responsible party will be notified of current status of PU. Initial notification, with significant change or at least monthly. Process Owner: DON or designee will report monthly to the facility QAPI meeting any issue with family notification. - All pressure ulcer care plans will be reviewed and updated per progress or decline, change in treatments, & new or changed orders. Process owner: MDS coordinator. - MDS coordinator or designee will report monthly to the facility QAPI meeting any issues noted with PU care plans. All residents with an acquired or admitted PU will have pain assessed r/t wound. Current tx interventions will be reviewed and Dr notified as needed for new interventions. See Weekly wound care assessment in PCC. - Process Owner: Director of Nursing or designee will report Pain concerns to the facility QAPI meeting monthly for review and recommendations. - All residents will have a weekly skin assessment completed by a licensed nurse		

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F 314	<p>Continued From page 43</p> <p>knowledge of wound and interventions, and hands-on observations of cares.</p> <p>--Audit will include turning and repositioning and observation of cushions and mattresses.</p> <p>--Pain management with PU will also be included in the audit.</p> <p>--Weekly skin assessments will also be audited and documented.</p> <p>-Process owner: DON. Results of the written audits will be reported weekly by the DON to the interim administrator. Further review will occur monthly at the facility QAPI meeting for further review and recommendations.</p> <p>*Task: Prevention of pressure ulcers.</p> <p>-Person(s) accountable: DNS or designee.</p> <p>-Root cause analysis: Noted increase in # [number] of acquired pressure ulcers.</p> <p>-Goal/plan: Ongoing.</p> <p>-Action steps: All residents with current skin breakdown or identified at risk (per Braden scale [score given for risk factors for pressure ulcers]) will have interventions in place to prevent further breakdown and healing of current skin issues. i.e. (for example) mattress, cushion, turning and repositioning schedule, dietary considerations, etc.</p> <p>--Licensed associates [staff] will be responsible to assure cushion placement is appropriate at time of placement.</p> <p>-Process owner: Director of nursing or designee will report monthly to the facility QAPI meeting on issues noted with prevention of pressure ulcers.</p> <p>*Task: Family notification.</p> <p>-Person(s) accountable: Wound care nurse/unit manager.</p> <p>-Root cause analysis: Potential issues identified by the state survey team.</p> <p>-Goal/plan: 8/7/14.</p> <p>-Action steps: All families or responsible party will</p>	F 314	<p>and documented on the Treatment record.</p> <p>If the resident refuses their bath, the assessment will still be completed on a weekly basis (no more than every 7 days)</p> <p>- Process owner: Director of Nursing. DON or designee will report the results of the skin assessments monthly to the facility QAPI committee for further review and recommendations.</p> <p>2. All residents have the potential to be affected.</p> <p>3. In addition to the above, A wound care certified nurse will in-service all staff NLT September 12, 2014 to reiterate proper care and interventions for those with pressure ulcers and interventions for pressure ulcer prevention. In-service will include the following: Pressure Ulcer identification, prevention, interventions, treatment, staging, documentation on wound flow log, reporting to physician, care planning, dietary involvement, and requesting treatment change from MD when no progress is made in wound healing. Those staff on vacation, sick leave, or casual status will be in-serviced prior to their return to work.</p> <p>4. The DON or designee will check all those with pressure ulcers each week to ensure care plan interventions are in place, treatment is done per MD order, residents are seen by a wound care certified nurse weekly, and treatments are appropriate. Audits will continue weekly for 4 weeks and then monthly. Results of audits</p> <p><i>*for two quarters. KWD/DH/MF</i></p>	

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F 314	<p>Continued From page 44 be notified of current status of PU. --Initial notification, with significant change or at least monthly. -Process owner: DON or designee will report monthly to the facility QAPI meeting any issue with family notification. *Task: Care plans. -Person(s) accountable: Wound care nurse, Minimum Data Set [MDS] coordinator, DON, charge nurse. -Goal/plan: 8/8/14. -Action steps: All pressure ulcer care plans will be reviewed and updated per progress or decline, change in treatments, & [and] new or changed orders. -Process owner: MDS coordinator or designee will report monthly to the facility QAPI meeting any issues noted with PU care plans. *Task: Pain. -Person(s) accountable: Wound care nurse/unit manager. -Goal/plan: 7/31/14 -Action steps: All residents with an acquired or admitted PU will have pain assessed r/t wound. --Current tx [treatment] interventions will be reviewed and Dr. notified as needed for new interventions. --See weekly wound care assessment in PCC [point click care electronic medical record]. -Process owner: DON or designee will report pain concerns to the facility QAPI meeting monthly for review and recommendations. *Task: Weekly skin assessment. -Person(s) accountable: Charge nurse. -Root cause analysis: Issue was previously identified by the facility and a plan was implemented. -Goal/plan: Ongoing. -Action steps: All residents will have a weekly skin</p>	F 314	<p>will be discussed by the DON at monthly Quality Assurance Process Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>5. September 12, 2014</p>	

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F 314	<p>Continued From page 45</p> <p>assessment completed by a licensed nurse and documented on the treatment record.</p> <p>--If the resident refuses their bath, the assessment will still be completed on a weekly basis (no more than every 7 days)</p> <p>-Process owner: DON or designee will report the results of the skin assessments monthly to the facility QAPI committee for further review and recommendations."</p> <p>During the standard survey on 7/31/14 at 1:45 p.m. the surveyors confirmed the immediate jeopardy situation had been abated (removed). Findings include:</p> <p>1. Observation of resident 4 on 7/29/14 at 8:30 a.m., 12:30 p.m., 2:45 p.m., 4:00 p.m., from 4:59 p.m. through 5:29 p.m., and at 6:20 p.m. revealed:</p> <p>*At 8:30 a.m. he was seated in his recliner. There was no pressure reducing cushion in that recliner.</p> <p>*At 12:30 p.m. he was still seated in his recliner with no cushion under him.</p> <p>*At 2:45 p.m. he was still seated in his recliner with no cushion under him.</p> <p>*At 4:00 p.m. he was still seated in his recliner with no cushion under him.</p> <p>*From 4:59 p.m. through 5:29 p.m. he had been assisted from his recliner and was seated in a wheelchair. There was no pressure reducing cushion in that wheelchair. He remained in the wheelchair until 6:20 p.m. He was then assisted to sit back in the recliner that had no cushion.</p> <p>*During the above observations it was noted resident 4 leaned towards his left side.</p> <p>Interview with resident 4 on 7/29/14 at 12:40 p.m., 2:45 p.m., and again at 4:59 p.m. revealed:</p> <p>*He usually waited a long time for someone to</p>	F 314		

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F 314	<p>Continued From page 46</p> <p>help him after he had turned on his call light. *He had been up before breakfast, and he would stay up until they helped him to bed around 8:00 p.m. *His bottom was "Really sore" and "It hurt like hell." *He leaned to his left, because his right buttock hurt so bad. *He did not feel "Like anybody cared much."</p> <p>Review of a 7/28/14 facsimile (fax) request sent by LPN C to resident 4's physician revealed: *The fax included: "Has 2 open areas to buttock open one is .5 X (by) .5 stage 2 (partial thickness loss of dermis [skin] presenting as a shallow open ulcer with a red pink wound bed, without slough [dead tissue]. May also present as an intact or open/ruptured serum [fluid]-filled blister) the other is .3 x .2 in coccyx [tailbone] area is open is stage 3 [full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure [hide] the depth of tissue loss. May include undermining [wound is wider at its base than on the surface] and tunneling [extends farther under the skin like a tunnel]. Can we use Hydrogel dressing covered with foam dressing to area daily." *The physician had replied "OK."</p> <p>Review of resident 4's July 2014 treatment administration record (TAR) revealed: *From 7/24/14 through the a.m. of 7/28/14 the treatment of "Apply INZO barrier cream to right buttock pressure area BID (twice daily) until healed." *That treatment was also documented as having been done the a.m. of 7/29/14. *The treatment had not been documented as</p>	F 314			

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F 314	<p>Continued From page 47 having been done in the p.m. of 7/28/14 or the p.m. of 7/29/14. *The treatment to apply INZO barrier cream to the right buttock pressure area BID until healed had been ordered by the physician on 7/23/14. *The treatment of Hydrogel dressing covered with foam dressing to the area daily was not on the July 2014 TAR.</p> <p>Observation of a wound care treatment for resident 4 on 7/30/14 at 9:35 a.m. by LPN C revealed: *He had two open areas. One was on his right buttock, and the other was on his coccyx. *There was no dressing present to either open area. *LPN C cleansed both areas with a wound cleanser and placed a piece of Hydrogel wound dressing on the two open areas. She then covered the Hydrogel with a secondary dressing of gauze and tape.</p> <p>Review of the interdisciplinary progress notes for resident 4 revealed: *He had been admitted on 7/23/14 from an acute care hospital. *He had a stage 1 pressure ulcer to his right buttock that measured 0.5 centimeters (cm) by 0.5 cm. *On 7/25/14 at 1:15 p.m. "Noted the top skin is off of red area on right buttock 0.5cm x 0.5cm. Calmoseptine (barrier cream) applied and reposition off of right buttock and pills (pillows) in place."</p> <p>Review of the 7/24/14 hospice interdisciplinary care plan revealed: **"Stage 1 0.2 cm x 0.2 cm." That note did not state where the stage one was located or if it was</p>	F 314		

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F 314	<p>Continued From page 48 a pressure ulcer or not. *"Low air loss mattress was delivered by _____ (durable medical equipment provider) during admission." *Under integumentary (skin) status section a pressure ulcer was listed as stage 1. *Remedy repair cream to have been applied BID.</p> <p>Review of resident 4's 7/23/14 initial wound sheet included: *His physician had been notified on 7/23/14 of the stage 1 pressure ulcer. *That pressure ulcer was measured at 0.5 cm x 0.5 cm with no depth and staged at a 1. *The wound treatment plan was to apply INZO barrier cream to the area BID. *It was to have been managed with off loading (taking pressure off of the affected area), a gel cushion, and a low loss air mattress.</p> <p>Review of resident 4's 7/28/14 wound assessment revealed: *"Resident has a pressure area to right buttock 0.5cm x 0.5 cm will get order for hydrogel and cover with foam border dressing. has open area to coccyx which measures .0. 0.3 cm x .2 cm will use hydrogel to this area also." *No staging had been done for those pressure areas.</p> <p>Interview on 7/30/14 at 1:30 p.m. with the interim administrator, the DON, and the director of clinical services revealed: *There were a "ton" of air overlays on beds in the facility for the prevention of pressure ulcers. *Pressure ulcer training was to have been done that day (7/30/14). *Therapy did the wheelchair cushions and positioning evaluations.</p>	F 314		

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F 314	<p>Continued From page 49</p> <ul style="list-style-type: none"> *They had no licensed nurse that was interested in wound care. *Documentation was not done on turning or repositioning. *They were aware there had been an increase in pressure ulcers. *Redevelopment of the wound care process had been planned. *There would be CNA (certified nursing assistant), licensed nurse (LPN or RN) training on pressure ulcer treatment. *Review of specific residents during the interview included: <ul style="list-style-type: none"> -Resident 1: Had been ill in January 2014, and she had heel protectors. -Resident 3: Treatment of Betadine to toes was not evidence-based (proved effective through scientific research and application). -Resident 4: They were not aware he had no pressure relieving cushions in his recliner or wheelchair. They were not aware the CNAs were not aware of his pressure ulcers. -Resident 10: He was not to have had shoes placed on his feet. They were not aware his shoes had been put on after his wound care treatment. *A pressure ulcer meeting had taken place on 7/15/14 with LPN C and the MDS (Minimum Data Set) assessment coordinator. They had physically visited all residents with pressure ulcers. Resident 4 had been missed for pressure relieving cushions. They had reviewed three residents daily to assess for pressure relieving cushions. *A weekly skin assessment for the nurses to complete had been started on 7/21/14. Before that time the bath aides should have notified the nurse if a skin problem had been noted. 	F 314		

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F 314	<p>Continued From page 50</p> <p>Interview on 7/31/14 at 11:30 a.m. with the medical director revealed:</p> <ul style="list-style-type: none"> *She had not been aware of the increased number of acquired pressure ulcers. *She stated the increase of pressure ulcers could have been attributed to the increase in acuity (level of the severity of a disease process) of residents that had been admitted. *She had been contacted by staff in regards to treatment options for pressure ulcers. *She stated she had relied on the provider's clinical resource specialist to give guidance on what were the best wound care interventions. *She had not been involved in the development of the provider's pressure ulcer policies. *She would consult a hospital's wound care clinic also for treatment options. *She only observed a resident's pressure ulcer if it was a large size pressure ulcer. <p>Surveyor: 29162</p> <p>2. Review of resident 1's medical record revealed:</p> <ul style="list-style-type: none"> *The "Skin/Wound notes" stated: <ul style="list-style-type: none"> -On 1/22/14 there had been a blister to her left heel that had not been open. It measured 5.4 cm by 5.4 cm. The order was to "Paint with Betadine until it gets healed?" -On 2/3/14 the blister to the left heel had opened. "Will continue with Betadine paint." -On 2/6/14 the blister remained. Total blister measured 6.0 cm. by 6.0 cm. The wound edges had been rolled and macerated [skin is softened and turns white from moisture]. No drainage. Open area measured 2.0 cm by 4.0 cm. "Continue with Betadine paint. -2/10/14 "Continue with Betadine paint." -2/17/14 Skin note stated "Resident continues to have blister to left heel. Area measures 3.0 by 5.0 	F 314		
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F 314	<p>Continued From page 51</p> <p>centimeters."</p> <p>-2/24/14 the notation stated, "Continues to have blister 3.0 cm. by 5.0 cm. Treating area on inner heel with Thera honey. No eschar [tan, brown, black scab]. Apply Betadine to peri wound [area around wound], apply therahoney to wound and cover with optifoam [type of dressing]. Change every 3 days."</p> <p>-3/3/14 Blister continues to left heel. Area measured 2.8 cm by 3.0 cm. No eschar. Periwound was macerated and measured 6.0 cm. by 5.0 cm. Changed treatment to Betadine daily with foam border dressing for protection.</p> <p>-3/10/14 Blister was soft and open whitish-yellow color to edges. Outside was pink in color. Had foam dressing on area that was saturated with drainage. Cleansed with Betadine and covered with optifoam. Measurements were 1.5 cm by .8 cm.</p> <p>-3/17/14 Heel ulcer measured 2 cm by 1.7 cm. Edema to lower legs. Note to physician to change dressing to paint area with Betadine and cover with calcium alginate foam dressing.</p> <p>*Per fax to physician:</p> <p>-3/25/14 Apply skin sealant to periwound and apply calcium alginate to wound bed. Cover with bordered foam. Change daily.</p> <p>-3/31/14 Will start therahoney to area and cover with foam dressing. Area measures 2 by 1 cm.</p> <p>-4/28/14 A referral with a wound care clinic for debridement was requested.</p> <p>-Further skin/wound notes and wound measurements had been done weekly at the wound care clinic. They were received back at the facility per fax.</p> <p>*The wound care clinic (wound care nurse):</p> <p>-First visit had been on 5/6/14.</p> <p>-Had not ordered Betadine for a treatment.</p> <p>-Determined the wound had undermining (wound</p>	F 314		

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F 314	<p>Continued From page 52</p> <p>being open underneath the lip of the border). -Stated per fax on 7/8/14 the wound had not been treated according to orders. "The previous dressing applied did not appear to have any packing. If you change the dressing-please fill dead space with order dressings." -Stated per fax on 7/8/14, "Please date dressing when changing so I can more accurately assess drainage." *Weekly wound assessments from 1/22/14 through 4/28/14 revealed: -The wound always had an odor. That odor had not been addressed. -The wound had declined in status for three different weeks. -The wound had not shown regular improvement until assistance from the wound care clinic for debridement (cleaning wound of dead tissue) and treatment had been requested. That time frame had been from 1/22/14 through 4/28/14.</p> <p>3. Review of resident 3's medical record revealed: *On 7/18/14 a progress note by LPN K stated, "Noted 1 cm. abrasion (scraped off area of skin) on the bottom of left big toe. Rubbed bottom of foot on head board." -No treatment had been started. -A nursing order for health maintenance had been entered on the MAR to monitor the abrasion. *On 7/22/14 an initial wound assessment for the resident's left outer foot had been completed by LPN K. It had been recorded as a pressure ulcer and had been 100% eschar and unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, black) in the wound bed).</p>	F 314		

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F 314	<p>Continued From page 53</p> <p>-The nursing order entered on the MAR had been to apply "Betadine paint" two times a day. -That had not followed this policy and procedure for pressure ulcers.</p> <p>*On 7/31/14 the resident had been seen by the wound care nurse, and a new treatment had been ordered. The order had been for "Collagen to open area and then cover with foam dressing."</p> <p>4. Review of resident 13's medical record revealed: *The resident had been readmitted on 9/3/13. *A skin assessment had been completed at the time of admission, on 9/9/13, and on 9/16/13. *There had not been a weekly skin assessment completed on 9/23/13 and on 9/30/13 by a licensed nurse. *The next skin assessment completed by a licensed nurse had been on 10/11/13 when a pressure ulcer had been identified to the sacral (bottom) area.</p> <p>Review of the bath aide skin checks on 9/5/13, 9/16/13, and 9/26/23 revealed no documentation under the heading "Skin assessment and outcome."</p> <p>Interview on 8/12/14 at 10:45 a.m. with the interim director of nurses regarding resident 13 revealed: *A skin assessment was to have been completed at the time of admission and then weekly for four weeks. *She stated after that time the bath aides did a skin check weekly. *She agreed that only the admission and first two weekly skin assessments had been completed by a professional nurse. *She agreed a professional nurse had not</p>	F 314		

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F 314	<p>Continued From page 54</p> <p>completed the last two skin assessments. A skin problem could have occurred during that time and not have been identified.</p> <p>Surveyor: 32572</p> <p>5. Review of resident 6's medical record revealed she had been admitted on 2/20/13. Review of the 1/22/14 revised care plan stated she was at risk for skin breakdown with that problem area initiated on 3/6/13.</p> <p>Review of resident 6's Braden scores (determines risk for pressure ulcers) from the electronic medical record (EMR) on the following dates revealed:</p> <ul style="list-style-type: none"> *Moderate risk with a score of 13 on 8/06/13. *Moderate risk with a score of 13 on 10/30/13. *High risk with a score of 12 on 12/22/13. *High risk with a score of 11 on 4/2/14. <p>Those scores showed an increased trending for risk of skin breakdown.</p> <p>Review of resident 6's wound documentation from the EMR revealed the right heel pressure ulcer measurements had no depth measurements and were indicated on all of the entries as length X (by) width:</p> <ul style="list-style-type: none"> *The initial wound notation had been on 10/2/13 as 5 cm X 3.5 cm and staged as suspected deep tissue injury (injury or damage to underlying tissue). That form had no indication the family had been notified of the pressure ulcer. *10/7/13, 4.5 cm X 3.5 cm; staged as suspected deep tissue injury. *11/4/13, 4.5 cm X 3.2 cm; staged as suspected deep tissue injury. The ulcer had 100 percent (%) eschar (scab). 	F 314		

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F 314	<p>Continued From page 55</p> <p>*12/02/13, 3.6 cm X 3.1 cm; staged as unstageable with 100% eschar.</p> <p>*1/13/14, 3.5 cm X 2.4 cm; staged as unstageable with 100% eschar.</p> <p>*2/03/14, 3.6 cm X 3.2 cm staged as unstageable with 100% eschar. No change was noted in the plan of care with the increase in wound size.</p> <p>*3/03/14, 3.5 cm X 3.2 cm; staged as unstageable with 100% eschar.</p> <p>*4/07/14, 3.0 cm X 3.0 cm; staged as unstageable with 100% eschar.</p> <p>*5/05/14, 1.8 cm X 2.8 cm; staged as unstageable with 100% eschar.</p> <p>*6/02/14, 1.8 cm X 2.8 cm; staged as unstageable with 20% granulation (healing tissue), 30% slough (dead tissue), and 50% eschar. No change was noted in the plan of care.</p> <p>*7/28/14, 1.4 cm X 1.4 cm; stated as unstageable with 100% eschar. No change was noted in the plan of care.</p> <p>*All of the above assessments indicated there had been pain associated with that pressure ulcer.</p> <p>*When changes in wound measurements occurred there had not been any documentation the family had been notified.</p> <p>Review of the wound care for the right heel ulcer had been initiated on 10/2/13 and included the following treatment:</p> <p>*Betadine (iodine) applied to the affected area twice a day.</p> <p>*On 10/7/13 heel protectors were applied and were to have been worn at all times. An air mattress overlay had been applied to the bed. Betadine was to have continued to be applied.</p> <p>*On 3/02/14 the wound care had been decreased to Betadine applications once a day.</p> <p>No alternative treatment had been investigated to</p>	F 314		

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F 314	<p>Continued From page 56</p> <p>promote wound healing when either no changes or an increase in the size of the wound had been noted.</p> <p>Review of the 8/2/13, 10/25/13, 1/17/14, 4/11/14, and 5/19/14 Minimum Data Set (MDS) assessments revealed the resident's overall status remained about the same:</p> <ul style="list-style-type: none"> *Her bed mobility (help moving in bed) had been extensive (majority of staff assistance) to total (staff complete the task with no resident help) assistance needed. *She had required extensive to total assistance from staff with transfers. *She required extensive to total assistance from staff with putting on and taking off her clothing. *She had required extensive to total assistance from the staff to eat. *She had been on a therapeutic (medically indicated diet) mechanical (ground) soft diet. <p>Observation on 7/29/14 at 3:50 p.m. with the DON of the right heel ulcer revealed a stage 3 (deep tissue that formed a crater) ulcer with slough present in the wound bed. No eschar was present. At that time the DON indicated the resident had obtained the ulcer in 2013 from moving her feet back and forth while in bed.</p> <p>6. Review of resident 10's medical record revealed he had been re-admitted on 2/9/12. Review of the 5/23/12 revised care plan from a previous admission revealed the problem area had been initiated on 3/8/11 and was being used as the current care plan. The focus area for skin breakdown had not been revised when pressure ulcer care had been initiated.</p> <p>Review of the 7/12/13, 10/2/13, 1/2/14, 3/27/14,</p>	F 314		

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F 314	<p>Continued From page 57</p> <p>and 6/16/14 Braden scores from the EMR revealed he had remained at moderate risk for skin problems.</p> <p>Review of the wound care documentation in the EMR revealed:</p> <p>*On 7/14/14 a pressure ulcer was noted on the right inner ankle that measured 0.4 cm X 0.4 cm X 0.2 cm. It had been a stage 3; with 10% slough. The family had not been notified.</p> <p>*The 7/21/14 assessment measured it at .6 cm X .6 cm X .2 cm stage 3 with 80% granulation and 20% slough. The assessment stated the wound had been stable. The physician or family had not been notified of the wound size changes.</p> <p>*The 7/28/14 assessment measured at 0.5 cm X 0.5 cm X 0.2 cm stage 3 with 80% granulation and 20% slough.</p> <p>Review of the wound care in the EMR for the right inner ankle pressure ulcer revealed:</p> <p>*On 7/14/14 wound care had been initiated to paint the area with Betadine and cover with Mepilex (name brand dressing). Heel protectors were to have been worn when in bed.</p> <p>*Wound care treatment had not changed when the pressure ulcer had increased in size.</p> <p>Review of the 7/5/13, 9/27/13, 12/20/13, 3/14/14, and 6/6/14 MDS assessments since this admission on 2/9/12 in the EMR revealed he had remained the same:</p> <p>*His bed mobility had been extensive assistance from staff.</p> <p>*He had required extensive assistance from staff with transfers.</p> <p>*He had required extensive assistance from staff for putting on and taking off clothing.</p> <p>*He had been independent with feeding himself.</p>	F 314		

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F 314	<p>Continued From page 58</p> <p>*He had been on a mechanically altered diet with no weight loss noted.</p> <p>Random observations from 7/29/14 through 7/31/14 revealed resident 10 was wearing a compression (snug fitting) stocking on the right leg. He was wearing white cotton anklet stockings and white high top tennis shoes on both feet.</p> <p>Observation and assessment of resident 10 on 7/30/14 at 9:35 a.m. with the DON revealed an ulcer on the inside of the ankle on the right foot without a dressing present. When the anklet and compression stocking had been removed by an unidentified nurse there had been redness in the surrounding skin. The high top tennis shoe and compression stocking had applied pressure to the surrounding area when worn.</p> <p>Interview at the above time with the DON confirmed resident 10 wore compression stockings, anklets, and tennis shoes each day. He had obtained the pressure ulcer after the family had purchased new tennis shoes (white high top shoes) for him. Staff were not to be putting the white tennis shoes on him, and he was to be wearing the old black tennis shoes. The DON could not confirm if the family had been told about the tennis shoes that had caused the skin problems.</p> <p>Interview on 7/30/14 at 10:10 a.m. with LPN C, the wound care nurse, confirmed the resident was to have been wearing his black tennis shoes. She continued to stage it at 3, because it had "Slough and it is deep."</p> <p>Surveyor: 26632 7. Interview on 7/31/14 at 11:30 a.m. with the</p>	F 314			

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F 314	<p>Continued From page 59</p> <p>medical director revealed:</p> <ul style="list-style-type: none"> *She had not been aware of the increased number of acquired pressure ulcers. *She stated the increase of pressure ulcers could have been attributed to the increase in acuity (level of the severity of a disease process) of residents that had been admitted. *She had been contacted by staff in regards to treatment options for pressure ulcers. *She stated she had relied on the provider's clinical resource specialist to give guidance on what were the best wound care interventions. *She had not been involved in the development of the provider's pressure ulcer policies. *She would consult a hospital's wound care clinic also for treatment options. *She only observed a resident's pressure ulcer if it was a large size pressure ulcer. <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, MO., 2005, p.1484, revealed "Pressure is the major element in the cause of pressure ulcers. Three pressure-related factors contribute to pressure ulcer development:</p> <ul style="list-style-type: none"> *Pressure intensity (amount of pressure required to close a capillary [blood vessel]). *Pressure duration (how long the pressure remains). *Tissue tolerance (the ability to handle pressure). <p>Review of the National Pressure Ulcer Advisory Panel, revised 2007 Pressure Ulcer Prevention Points talksheet revealed: "Implementation of pressure ulcer prevention program are structured, organized, comprehensive, and directed at all levels of health care providers, patients, family, and caregivers." Included information on:</p> <ul style="list-style-type: none"> **Etiology [cause] of and risk factors for pressure 	F 314		

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F 314	<p>Continued From page 60</p> <p>ulcers." **Risk assessment tools and their application." **Skin assessment." **Selection and use of support surfaces [gel cushions]." **Nutritional support [supplements]." **Program for bowel and bladder [incontinence] management." **Development and implement individualized programs of skin care." **Demonstration of positioning to decrease risk of tissue breakdown." **Accurate documentation of pertinent data."</p> <p>Review of the provider's February 2014 Pressure Ulcers/Skin Breakdown policy revealed: *The nursing staff and attending physician would assess and document an individual's significant risk factors for development of a pressure ulcer. *The nurse should assess and document/report the following including: -Full assessment of pressure ulcer including location, stage, length, width, and depth. -Pain assessment. -Current treatments, including support surfaces. *The physician would authorize orders related to wound treatments including pressure reduction surfaces, wound cleansing and debridement (removal of dead tissue) approaches, dressings, and the application of topical (to the skin) agents.</p> <p>Review of the provider's February 2014 Pressure Ulcer Treatment policy revealed: **The pressure ulcer treatment program should focus on the following strategies: -Assessing the resident's pressure ulcer(s). -Managing tissue loads. -Pressure ulcer care. -Managing infection.</p>	F 314		

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F 314	Continued From page 61 -Education and quality improvement. *When eschar [scab] is present, a pressure ulcer cannot be accurately staged until the eschar is removed. *Stage one pressure ulcer: Intact skin with non-blanchable [does not become pale when pressed] redness of a localized area usually over a bony prominence. *Stage two pressure ulcer: Partial thickness loss of dermis [skin] presenting as a shallow open ulcer with a red pink wound bed, without slough [dead tissue]. May also present as an intact or open/ruptured serum [fluid]-filled blister. *Stage three pressure ulcer: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure [hide] the depth of tissue loss. May include undermining [wound is wider at its base than on the surface] and tunneling [extends farther under the skin like a tunnel]. *Stage four pressure ulcer: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. *Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, black) in the wound bed. *Pressure ulcer treatment requires a comprehensive approach, including: -Debridement, managing infections, maximizing the potential for healing, and pain control. *Stage one pressure ulcer interventions included: -Implement pressure relieving device. -Turn schedule. *Stage two pressure ulcer interventions included: -Protect, manage drainage, manage pain, and	F 314			

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F 314	Continued From page 62 promote a moist wound healing environment. -If wound does not improve in two to three weeks notify the physician. *Stage three pressure ulcer interventions included: -Protect, manage drainage, promote a moist wound healing environment, and manage pain. *Stage four pressure ulcer interventions included: -Protect, manage drainage, promote a moist wound healing environment, and manage pain. *Information should be recorded in the resident's medical record that included: -The type of treatment and resident response. -The date and time the wound care was given. -All assessment data (i.e. color, size, pain, drainage, etc.) when inspecting the wound."	F 314			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Surveyor: 20031 Based on observation and interview, the provider failed to ensure: *One of one chemical supply rooms remained locked in one of three wings (400 wing). *Prescription and over-the-counter medications	F 323	F323 1. The chemical supply room is locked and prescription and over the counter medications were removed from the therapy room. 2. All residents have the potential to be affected. 3. The DON will in-service all staff NLT September 12, 2014 on the requirements to keep supply doors locked and that all medications must be stored in a secure location. Those staff on vacation, sick leave, or casual status will be in-serviced prior to their return to work. 4. The DON or designee will randomly check supply room doors 4X weekly to ensure they are locked and will check 4 random office areas to ensure there are no	9-12-14	

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F 323	<p>Continued From page 63</p> <p>were secured in one of one therapy room. Findings include:</p> <p>1. Observation on 7/29/14 at 8:10 a.m. revealed the chemical storage closet on the 400 wing was open and unlocked. There was a sign on the door to that closet that stated it was to have been kept locked at all times. Observation at 11:00 a.m. on the same day revealed that storage closet remained open and unlocked (photos 1 and 2). Residents were observed walking in the hallway by this room frequently.</p> <p>Interview on 8/12/14 at 2:35 p.m. with the director of plant operations revealed the above door was to have been kept closed and locked at all times unless staff were in attendance.</p> <p>Surveyor: 20031</p> <p>2. Observation on 8/12/14 at 2:00 p.m. revealed four medication bottles stored in an unlocked drawer in the therapy room. Three bottles were labeled Advil (non-prescription pain medication) and were outdated. The fourth bottle was labeled as a prescription drug.</p> <p>Interview with employee H at that time confirmed the above. He stated the above were his medications to use for pain in his ankle. He was not aware over-the-counter medication and prescription medications should have been secured away from residents. Additional interview at that same time with the director of rehabilitation revealed he was unaware those medication bottles were in that drawer. He had employee H remove and secure the medication at that time. The director stated the department had no policy for storage of personal items. He stated most rehabilitation employees kept their personal items</p>	F 323	<p>prescription or over the counter medications assessable. Audits will continue weekly for 4 weeks and then monthly. Results of audits will be discussed by the DON at monthly Quality Assurance Process Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>5. September 12, 2014 * for two quarters. KW/SDDOH/ME</p> <p>* All staff, including contracted therapy staff, were educated. KW/SDDOH/ME</p>	

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F 431	Continued From page 65 This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, interview, and policy review, the provider failed to account for controlled scheduled medications (any drug commonly understood to include narcotics with a potential for abuse or addiction which is held under strict government control) awaiting destruction in three of three medication carts. Findings include: 1. Observation on 8/12/14 from 4:55 p.m. through 5:30 p.m. of the 200, 300, and 400 wing medication carts revealed there had been schedule II and III medications in the locked narcotic boxes on the medication carts. Those medications had been placed there prior to destruction. Those medications had the narcotic accountability records folded around them. Interview on 8/12/14 at 5:10 p.m. with licensed practical nurse (LPN) A revealed: *The schedule II and III medications in the medication cart that were awaiting destruction were: -Placed in the back of the narcotic drawer in the medication cart. The accountability record for those medications was folded around the medication cards, bottles, or boxes. -Not included in the nurse's change-of shift narcotic accountability count. -Taken to director of nurses (DON) and destroyed with her when he saw them in the drawer. *The DON had not been available on weekends, evenings, or overnights to destroy the narcotics.	F 431			

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F 431	Continued From page 66 *He agreed the schedule II and III medications awaiting destruction in the 300 hallway medication cart had not been accounted for. Interview on 8/12/14 at 5:15 p.m. with LPN C and at 5:20 p.m. with LPN B confirmed the above information provided by LPN A. Interview on 8/12/14 at 5:25 p.m. with the interim director of nurses revealed she expected the nurses to continue to include all schedule II and III medications in the change of shift narcotic count. That would have been done until the medications were removed from the cart. Review of the provider's revised July 2013 Medication Destruction policy revealed it did not address accountability of schedule II and III medications awaiting destruction.	F 431			
F 441 SS=D	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.	F 441	F441 1. Oxygen tubing found to be on the floor was discarded and replaced. No immediate correction could be made for Resident 2. CNA's immediately in-serviced on hand washing and glove use. The razor found in therapy gym was removed and discarded. The foam wedges have been replaced and include a cleanable cover. 2. All residents have the potential to be affected. 3. The DON will in-service all staff, including contracted therapy staff, NLT September 12, 2014 on the following:	8-12-14	

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F 441	<p>Continued From page 67</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 20031</p> <p>Surveyor: 23059 Based on observation, interview, and policy review, the provider failed to ensure proper infection control techniques were used for the following: *Storage of five of five random oxygen (O2) concentrator tubings in random resident's rooms when not in use. *One of two observations of personal care by two of four certified nursing assistants (CNA) (D and E) for one of two residents (2) observed. *Two of three foam therapy wedges used for any resident. *One of one electric razor in the therapy room</p>	F 441	<p>Hand washing procedure and glove use; items used for multiple residents must be cleanable and need to be sanitized between multiple resident use; and that electric razors will not be shared among residents. Those staff on vacation, sick leave, or casual status will be in-serviced prior to their return to work.</p> <p>4. The DON or designee will check 4 random cares each week to staff wash hands and use/change gloves per policy. Additionally, audits will include 4 random care areas to ensure items used for multiple residents are cleanable and that electric razors are not used on multiple residents. Audits will continue weekly for 4 weeks and then monthly. Results of audits will be discussed by the DON at monthly Quality Assurance Process Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>5. September 12, 2014</p> <p><i>*for two quarters. kw/SDOH/ME</i></p>	

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F 441	<p>Continued From page 68 was cleaned between residents' use. Findings include:</p> <p>1. Observations on 7/30/14 beginning at 7:40 a.m. revealed O2 tubing from concentrators were laying on the floor uncapped in five random resident room observations.</p> <p>Interview on 7/30/14 at 7:50 a.m. with CNA F revealed O2 tubing was to have been coiled and placed in a bag on the O2 concentrator when not in-use. She stated it should never have been left uncapped on the floor.</p> <p>Interview on 7/31/14 at 10:45 a.m. with licensed practical nurse G revealed all CNAs had been instructed to place O2 tubing in the bag on the concentrator when not in-use.</p> <p>Review of the provider's revised April 2014 Oxygen Concentrator Usage policy revealed the O2 cannula or mask was to have been stored so as not to touch the floor when not in-use. There was nothing in that policy regarding the care of the concentrator tubing when not in-use.</p> <p>2. Observation on 7/29/14 at 3:15 p.m. of personal care for resident 2 revealed CNAs D and E washed their hands upon entrance into the room. After washing their hands they both put on a pair of gloves. With those gloved hands they:</p> <ul style="list-style-type: none"> *Repositioned resident 2 in bed. *Pulled down his sweat pants. *Removed his soiled brief. *Cleaned his bottom (peri-care) with wipes. *Applied a clean brief. *Pulled up his pants. *Repositioned him in bed. *Pulled up the bedding. 	F 441		

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F 441	<p>Continued From page 69</p> <p>At that point they removed their soiled gloves and washed their hands.</p> <p>Interview on 7/29/14 at 3:23 p.m. with CNA E revealed the above was their usual practice.</p> <p>Interview on 7/31/14 at 9:00 a.m. with the infection control coordinator revealed the gloves should have been changed when they had been soiled (after cleaning the resident's bottom).</p> <p>Review of the provider's revised May 2014 Glove Usage policy revealed: *When peri-care had been completed gloves were to have been removed and hands washed. *Clean gloves were to have been applied before placing clean undergarments or briefs.</p> <p>Surveyor: 20031 3. Observation on 8/12/14 at 2:00 p.m. in the therapy room revealed two foam wedges had been placed on the exercise table. Those two wedges had no cover on them. Interview at the time of the observation with the director of rehabilitation (rehab) confirmed those wedges had no covers. He stated staff would cover the foam wedge with a pillow case when used on a resident. He agreed there was no technique to disinfect the foam wedge itself.</p> <p>Additional observation at that time in the therapy room revealed an electric razor in a cabinet drawer. Upon opening that razor whiskers and other debris spilled out of the head into this surveyor's hand. Interview at the time of the observation with the director of rehab confirmed that finding. He stated they used that razor in therapy for residents who wanted to use an electric razor. It was to have been cleaned and</p>	F 441			

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F 441	Continued From page 70 disinfected between each use.	F 441		
F 490 SS=F	<p>Review of the 8/1/13 Rehab Department Cleaning and Maintenance Schedule policy revealed "Equipment will be checked sanitized and maintained according to its specific properties and manufacturer's recommendations."</p> <p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, record review, and policy review, the provider failed to ensure the facility was operated and administered in a manner that attained or maintained the highest practicable physical, mental, and psychosocial well-being of all seventy-nine residents. Findings include:</p> <p>1. Interview on 8/13/14 at 9:40 a.m. with the administrator confirmed the overall operation and administration of the facility was her responsibility.</p> <p>Interviews, observations, record reviews, and policy reviews throughout the course of the survey 7/29/14 through 7/31/14 and 8/12/14 through 8/13/14 revealed the administration had not ensured all seventy-nine residents attained</p>	F 490	<p>F490</p> <ol style="list-style-type: none"> No immediate corrective action could be taken. All residents have the potential to be affected. The Administrator is currently on a medical leave. Upon her return she will review her job description. She will have weekly conference calls/visits by the Director of Operations. The Director of Operations will call and /or visit weekly for one month and then as needed. Any problems encountered will be reported to the monthly Quality Assurance Process Improvement (QAPI) meeting for further review and recommendations Upon return from medical leave. <p><i>*Weekly calls or visits with the Director of Operations will be for four weeks and then bi-monthly times 5 months. KW/SDDOH/MF</i></p>	9-12-14

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F 490	Continued From page 71 and/or maintained their highest practicable physical, mental, and psychosocial well-being. Refer to F151, F166, F176, F223, F226, F250, F253, F280, F309, F314, F323, F431, F441, F514, and F520.	F 490			
F 514 SS=F	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Surveyor: 26632 Based on record review, interview, and policy review, the provider failed to ensure complete and accurate documentation had been provided for: *One of one sampled resident (11) that wandered and had behaviors that affected other residents. *Two of two residents (2 and 8) had a laboratory test completed per physician's orders. *One of one resident (2) whose wound care dressing was not available.	F 514	F514 1. No correction can be made to documentation in Resident 11's medical record. Resident 11 was discharged at the time of survey. Resident 2's physician was called and the ordered testing was discontinued. Resident 8's lab testing has been completed. No immediate correction can be completed for Resident 2's incomplete documentation surrounding scheduled treatment. Resident 12's medical record has been corrected to omit the incorrect documentation. No immediate correction could be taken for Resident 3's missing documentation describing the need for an as needed medication. Resident 2's treatment orders were changed at the time of survey. 2. All residents have the potential to be affected. 3. The DON will in-service all nursing staff NLT September 12, 2014 on documentation requirements, including documentation of why an as needed medication/treatment is given; lab results and follow up; and ensuring the right resident is documented on and how to correct the documentation if it is made in error. Those staff on vacation, sick leave,	9-12-14	

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F 514	<p>Continued From page 72</p> <p>*One of one resident (12) whose medical record had wrong information regarding a pressure ulcer.</p> <p>*One of one resident (3) that had received an anti-psychotic medication for behaviors.</p> <p>*One of one resident (2) who had an as needed dressing change to his pressure ulcer.</p> <p>Findings include:</p> <p>1. Review of resident 11's interdisciplinary progress notes revealed: *A late entry on 5/31/14 at 3:01 p.m. "Resident was found outside of the front door sitting in a person's car. The day was about 65-70 degrees outside. When returning inside he showed no signs of dehydration or injuries. Normal behavior was observed for an individual with dementia and wandering." *A late entry on 5/31/14 at 6:45 p.m. "Resident was sexually inappropriate with CNAs [certified nursing assistant]." *A 6/1/14 at 6:47 p.m. note "Resident was being sexually inappropriate with CNAs." *A 6/2/14 note at 9:11 p.m. "Resident was up wandering and headed outside but was stopped before he made out the doors." *A 6/2/14 at 9:13 p.m. note "Resident was being sexually inappropriate with the CNAs." *A 6/10/14 at 3:46 p.m. a care area assessment (CAA) for resident behaviors "Resident has Alzheimer's and has behavior d/t [due to] this. He wanders around is not aware of his surroundings. He also has been making sexually inappropriate comments to staff. He did wander at home but not sure if he had other behaviors. His behaviors are easily controlled at this time." *A 6/11/14 at 4:19 a.m. note "Resident has been awake most all of shift wandering around building going into other resident's rooms turning on water</p>	F 514	<p>or casual status will be in-serviced prior to their return to work.</p> <p>4. The DON or designee will check 4 random medical records weekly to ensure documentation is complete and accurate. Audits will continue weekly for 4 weeks and then monthly. Results of audits will be discussed by the DON at monthly Quality Assurance Process Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>5. September 12, 2014</p> <p><i>* for two quarters. KW/SDDOCH/MF</i></p> <p><i>* The MAR/TAR, IPNS and Labs and MD orders will be audited. KW/SDDOCH/MF</i></p>		

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F 514	<p>Continued From page 73</p> <p>in bath rooms or lights sitting in chairs in rooms several female residents reported being scared by him."</p> <p>*A 6/24/14 at 5:42 a.m. note "Resident at 2:30 a.m. was found in bed in _____ (room and bed number) with female resident. He was removed from the room and directed back to his room where he stayed for most of the night."</p> <p>*A 7/2/14 at 12:30 a.m. note "Resident in room _____ [Resident 30] is yelling @ [at] him to get out and using her walker to direct him out and _____ [resident 27] is attempting to hit him with her pillow and telling him to get away from her, both women very upset, the report they wake up with him standing over them telling them to get up. _____ [resident 11] escord [escorted] out of their room and taken back to his to use the BR [bathroom]."</p> <p>*A 7/13/14 at 4:54 a.m. note "Resident becoming more combative with staff when trying to redirect him out of other's rooms or put clothes on him after he takes them off. Did attempt to leave building 1 time, got as far as between the front doors before staff turned him around."</p> <p>*A 7/16/14 at 2:14 p.m. activities aide note "I spent a lot of 1 on 1 times with _____ [resident 11] today. He is confused and tends to wander in other residents' rooms which is very upsetting to many of them. He was able to work with wooden blacks and dominoes but needed constant cueing d/t dementia. He did read several items in the newspaper. When he became restless, we offered him the restroom and something to eat/drink, which did calm him down. Did take a short nap in recliner in the activity room before lunch."</p> <p>*A 7/27/14 at 5:23 a.m. note "On 7/26/14 at 2145 (9:45 p.m.) resident reached down inside of female CNA's top and tried to fondle her breasts</p>	F 514		
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F 514	<p>Continued From page 74</p> <p>resident was told that this was not allowed and was redirected back to his room and toileted by CNA and male nurse, when done resident then made comment that he would make it all right if she came to bed with him...At 2330 (11:30 p.m. on the same evening resident was found groping female resident's [rm ____] [resident 29] breasts and was informed that this was not allowed at which time he just chuckled and hit the CNA several times. Resident was redirected to a recliner in the open court where he stayed most of the shift."</p> <p>*A 7/30/14 at 5:00 a.m. note "Resident walked up to a female resident [resident not identified in note] and dropped his pants, CNA intervene promptly and escort resident after helping to pull up pants out of the area."</p> <p>*A 8/3/14 at 8:50 p.m. note "Resident in room _____, shaking _____ [resident 22], turning buttons on resident C-PAP [continuous positive air pressure] machine. Resident 22 was yelling and I went in and attempted to redirect."</p> <p>*A 8/7/14 at 1:30 a.m. note "Was asked to resident out of another residents room, when attempt to escort him out he told me to shut up, hit my hand away and slapped [slapped] my mouth. While leaving the area he cont [continued] to tell me to shut up and attempt to hit my mouth and hand several times. Did get to his room and sat on bed, would not lay down and told me to leave. Report off to CRA that were caring for him, they would F/U [follow up] on him."</p> <p>*A 8/8/14 at 2:31 p.m. physician's orders note "Resident was seen this afternoon by _____ [physician's name] for 30 day review." There was no mention of resident 11's behaviors or wandering.</p> <p>*A 8/9/14 at 9:30 a.m. note a facsimile had been sent to his physician that included a possible</p>	F 514		

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F 514	<p>Continued From page 75</p> <p>order for some melatonin to assist with his sleep.</p> <p>*A 8/10/14 at 10:45 p.m. note "Resident found in another residents room, attempting to get her up and take him to BR, cursing @ (at) her and tugging on her leg to get up. Resident 22 becoming upset and little scared. Appologis [apologies] as he was being removed from her room. Resident 11 hitting @ staff and telling her to shut up."</p> <p>*A 8/10/14 at 11:00 p.m. note "Resident from room ____ [resident 19] out @ the nurse's station asking for staff to come and removed ____ [resident 11] from her room, he is telling ____ [resident 28] to get up and come with him, he needs to use the toilet and needs "Mamma's help", resident escorted out and taken to his BR, he is little aggressive tonite and telling staff to leave him alone, shut up and attempting to hit the staff."</p> <p>*A 8/10/14 at 11:30 p.m. note "Resident was in room ____ [resident 22] attempting to get into bed with that resident who was screaming for help. ____ [resident 11] was removed but he was also attempting to hurt staff and call her names."</p> <p>*A 8/11/14 at 12:00 a.m. note "Resident again back into Rm [room] ____ [resident 22], telling her to get up and pulling @ her feet. Her room is dark and he is able to get to her bedside by the window and wake her up. She has request to some how keep him out, she has agree [agreed] to shut her door to see if that will stop him, cont to monitor and apologies for the incident."</p> <p>*Those above notes had not shown the follow-up with the resident in regards to his wandering and behaviors.</p> <p>Interview on 8/12/14 at 4:30 p.m. with the interim administrator and the director of clinical services</p>	F 514		

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F 514	<p>Continued From page 76</p> <p>revealed there were aware the documentation in the interdisciplinary progress notes had not followed the standard of nursing documentation.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, MO., 2005, p. 477, revealed:</p> <p>***"Documentation is anything written or printed that is relied on as record or proof for authorized persons."</p> <p>***"Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client (resident) outcomes, and reflect current standards of nursing practice."</p> <p>***"Descriptive, objective information about what a nurse sees, hears, feels, and smells."</p> <p>***"The medical record is a legal document and requires information describing the care that is delivered to a client."</p> <p>***"Information on the client record provides a detailed account of the level of quality of care delivered to clients."</p> <p>***"Effective documentation ensures quality of care and minimizes the risk of errors."</p> <p>Surveyor: 23059</p> <p>2. Review of resident 2's 5/6/14 physician's orders revealed an order for a stool culture to test for clostridium difficile (C. Diff) (a bacteria in the intestine that can cause very loose stools).</p> <p>Review of the resident's laboratory (lab) results since 5/6/14 revealed no results for the C. Diff testing. Review of the resident's nurse's notes revealed there was no documentation regarding whether or not that testing had been completed.</p> <p>Interview on 7/30/14 at 9:30 a.m. with the director</p>	F 514		

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F 514	<p>Continued From page 77</p> <p>of clinical services and the unit manager revealed the C. Diff testing had not been done for resident 2. They stated his loose stools had stopped, so no testing was done. Both confirmed there was no documentation to indicate:</p> <ul style="list-style-type: none"> *Why the testing had not been done. *Resident 2's loose stools had stopped. *The physician had been notified the testing had not been done. *An order had been received to discontinue the C. Diff testing. <p>Surveyor: 32572</p> <p>3. Review of resident 8's medical record revealed a 1/7/14 physician's order for Depakote (seizure medication) level lab (test for medication monitoring) every six months in January and June 2014. That lab test had been completed in January 2014. No lab results were in the medical record for June 2014.</p> <p>Interview on 7/30/14 at 8:57 a.m. with the director of clinical services confirmed the lab test should have been done in June 2014. There were no lab results in the medical record. He asked the health unit coordinator (HUC) to call the lab to obtain the results at that time. At 9:20 a.m. the director of clinical services notified this surveyor the Depakote level had not been completed as ordered.</p> <p>Surveyor: 23059</p> <p>4. Review of resident 2's 7/22/14 physician's orders revealed an order for Hydrogel (dressing consisting of a gel in the form of a sheet) with with a foam dressing to the open area on his lower back.</p> <p>Observation on 7/29/14 at 3:15 p.m. revealed</p>	F 514			

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F 514	<p>Continued From page 78</p> <p>licensed practical nurse (LPN) A applied a Mepilex dressing to the wound. The Hydrogel with foam dressing was not used. Interview with LPN A at that time revealed the Hydrogel was not available at that time, so he chose to use the Mepilex instead.</p> <p>Review of resident 2's treatment administration record revealed a space to document the application of the Hydrogel with the foam dressing. LPN A's initials were in the box as having completed that dressing change. In that box was also the code "11." That code indicated "Medication unavailable/See nurse's notes." Review of the 7/29/14 nurse's notes revealed there was no documentation to indicate why the Hydrogel and foam dressing were not used.</p> <p>Interview on 7/30/14 at 9:30 a.m. with the director of clinical services and the director of nursing revealed they would have expected the reason the Hydrogel was not used to have been documented in the nurse's notes. They confirmed no documentation was found in the nurse's notes regarding the above.</p> <p>5. Review of resident 12's 7/22/14 nurse's notes revealed he had a dressing change to his right buttock. Review of his 7/29/14 nurse's notes revealed he had a new open area on his coccyx (tail bone). Review of his skin assessment revealed the first documentation of an open area was on 7/29/14.</p> <p>Interview on 7/31/14 at 7:40 a.m. with the director of nursing revealed resident 12 did not have an open area that required a dressing change until 7/29/14. She stated: *She did not know why there was documentation</p>	F 514			

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F 514	<p>Continued From page 79</p> <p>on 7/22/14 that there was a dressing change to his right buttock.</p> <p>*She assumed that had been documented on the wrong chart.</p> <p>*She could not talk with the nurse who had completed that documentation, as she was out of town for personal reasons.</p> <p>Interview on 8/13/14 at 9:15 a.m. with the director of clinical services revealed the 7/22/14 documentation was in error. He stated he visited with the nurse who documented it, and she was unsure as to why that documentation had occurred.</p> <p>Surveyor: 29162</p> <p>6. Review of resident 3's progress notes revealed a notation on 7/26/14 at 10:37 p.m. regarding medication administration. The resident had received Haldol 0.2 ml (milliliter) intramuscularly (a shot in the muscle) for anxiety or agitation per the medication order. There had been no documentation in the progress notes prior to giving the resident the medication to indicate the need for it to have been given.</p> <p>Surveyor: 32333</p> <p>7. Review of resident 2's August 2014 treatment administration record (TAR) revealed an order to change his dressing to his left buttock as needed (PRN). That had been documented as completed on 8/1/14 and 8/12/14.</p> <p>Review of resident 2's August 2014 progress notes revealed:</p> <p>*A note on 8/1/14 that stated "Butt wound replaced dressed with hydrogel and bordered foam drsng [dressing]."</p> <p>*A note on 8/12/14 that stated "Dressing dirty,</p>	F 514			

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NAME OF PROVIDER OR SUPPLIER BELLE FOURCHE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 13TH AVE BELLE FOURCHE, SD 57717		
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F 514	Continued From page 80 changed." *There had been no further documentation regarding the dressing changes on the above mentioned dates. Interview on 8/13/14 at 10:35 p.m. with the director of clinical services revealed: *The computer system required a note when a PRN dressing change was documented in the TAR. *The progress notes above were not complete. *He would have expected progress notes on PRN dressing changes to have been complete. Review of the provider's revised February 2014 Pressure Ulcer Treatment policy revealed the following documentation should have been recorded in the resident's medical record: **"The position in which the resident was placed." **"Any change in the resident's condition." **"All assessment data (i.e.[for example], color, size, pain, drainage, etc.[etcetera]) when inspecting the wound." **"Resident tolerance of the procedure." **"Any problems or complaints made by the resident related to the procedure."	F 514			
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance	F 520	F520 1. No immediate correction could be taken for the QAPI meeting's missing members or missing documentation. 2. All residents have the potential to be affected. 3. The Director of Clinical Services will in-service all QAPI members on the NLT September 12, 2014 on the QAPI processes and required attendance.	9-12-14	

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F 520	<p>Continued From page 81</p> <p>committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, record review, interview, and policy review, the provider failed to ensure an effective quality assessment and performance improvement (QAPI) program had been maintained to:</p> <ul style="list-style-type: none"> *Identify residents' concerns. *Act on those identified concerns with a developed corrective action plan. *Set goals for the identified concerns. *Evaluate the corrective action plan. *Re-adjust the corrective action plan as needed to obtain the set goals for the identified concerns. *Ensure the medical director attended the QAPI meeting at least quarterly. *Ensure the administrator and director of nursing (DON) attended the monthly meetings. <p>Findings include:</p> <p>1. Review of the provider's QAPI meeting minutes</p>	F 520	<p>4. The Director of Clinical Services will attend the next QAPI meeting and monthly meetings as needed. The Director of Clinical Education will review QAPI meeting minutes for 3 months and make recommendations to the team as needed. After 3 months the Director of Clinical Education will determine if the QAPI team needs additional oversight and will provide additional training as needed.</p> <p>5. September 12, 2014</p> <p><i>* All staff are invited to attend QAPI meetings. A member from each department will attend the QAPI meeting. A CNA, or charge nurse will be invited to attend each month. KJ/SDDH/MF</i></p>		

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F 520	<p>Continued From page 82 from 1/14/14 through 7/15/14 revealed:</p> <ul style="list-style-type: none"> *The medical director had only attended the QAPI meeting on 2/11/14. *The administrator had not attended the 4/8/14 QAPI meeting. *The DON had not attended the 4/8/14 and 5/13/14 QAPI meeting. *The QAPI committee had identified areas that included falls, answering of call lights promptly, meal service, dining room noise volume, bedtime snacks, and psychoactive medications. *There had been information from audits that had been previously completed. *The response from the QAPI committee had been "Will continue to monitor." *There had been no goals set for those identified areas. <p>Interview on 7/31/14 at 11:30 a.m. with the medical director revealed:</p> <ul style="list-style-type: none"> *She did not attend the QAPI meetings as often as she wanted to. She was not aware the last time she had attended the QAPI meeting was 2/11/14. *She was not aware before 7/30/14 of the issues with pressure ulcers. *She did not receive the QAPI meeting minutes when she had not attended the meeting. *She was informally consulted regarding the development of the provider's policies and procedures. <p>Interview on 8/13/14 at 9:30 a.m. with the social service designee who was also the head of the QAPI program revealed the program and participants:</p> <ul style="list-style-type: none"> *Had no measurable goals or interventions. *Had no corrective plans to address areas of concern identified at QAPI meetings. 	F 520			

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F 520	<p>Continued From page 83</p> <ul style="list-style-type: none"> *Meetings had been reactive and not proactive. *Reviewed the monthly resident council meeting minutes for issues. *Discussed the studies done, but no action plans had been documented. <p>She agreed they only "Continued to monitor" the audits. She agreed the current process had been ineffective.</p> <p>Interview on 8/13/14 at 9:40 a.m. with the administrator revealed she:</p> <ul style="list-style-type: none"> *Was not aware the medical director had only attended one QAPI meeting so far in 2014. *Agreed both the DON and herself had missed QAPI meetings. *Agreed the QAPI process had not been followed to correct identified areas. *Agreed the documentation of the QAPI program did not reflect any actions taken to correct identified concern areas. <p>Review of the provider's revised January 2014 Quality Assessment and Assurance policy revealed:</p> <ul style="list-style-type: none"> *The governing body and administration would support and maintain an effective facility wide QAPI program. *The professional and administrative staff monitored and evaluated the quality and appropriateness of resident care and clinical performance of resident care staff. *Resident concerns were identified, resolved, and reported to the administrator and governing body of the facility. *The quality improvement program was designed to objectively and systematically monitor and evaluate the quality and appropriateness of resident care. *The intent was to identify barriers to the 	F 520		

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F 520	Continued From page 84 provision of quality resident care, establish standards of practice, and to have measurable outcomes by which to evaluate the services. *All quality improvement activities would be integrated and coordinated among all departments and services through the QAPI committee that would meet monthly. *The quality of clinical services including the identification of trends in performance, were monitored and evaluated. *Root cause analysis would be conducted on areas of concern and an action plan developed by the committee. *Those areas of concern could include: resident rights, resident behavior, administration, resident assessments and care plans, nursing services, quality of life, quality of care, resident grievances, staff development, survey and compliance, and physician services. *Through committee and consultant review facility-wide quality improvement monitoring also included but was not limited to incidents, accidents, and unusual occurrences, resident and family satisfaction surveys, quality indicators, documentation of nursing care, vulnerable adult reports, and survey and compliance. *The QAPI committee would meet each month to review topics that included clinical outcomes, resident satisfaction surveys, resident census, drug utilization, pharmacy reviews, care practices, infection trending, survey compliance, and other needed facility topics. *The QAPI committee would meet no less than monthly and had on its membership the department heads and nurse managers. *The full QAPI committee would meet quarterly and consisted of the medical director, administrator, director of nursing, all other department heads, and the consultant	F 520			

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F 520	Continued From page 85 pharmacist. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, MO., 2005, p.365, revealed" ...organizations must be responsible and accountable for evaluating and improving the quality of client care services being provided to all clients. This requires health professionals at all levels to critically evaluate their practices, to incorporate the latest scientific findings into client care, and to measure the success of meeting client outcomes on an ongoing basis." Refer to: F166, F223, F226, F250, F309, and F314.	F 520			

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NAME OF PROVIDER OR SUPPLIER BELLE FOURCHE HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 13TH AVE BELLE FOURCHE, SD 57717
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 20031 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted from 8/12/14 through 8/13/14. Belle Fourche Healthcare Center was found 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 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Interim Administrator</i>	(X6) DATE <i>8-29-14</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 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.

