

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

ORIGINAL

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2014
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NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442
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F 000	INITIAL COMMENTS Surveyor: 32572 78A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/23/14 through 6/25/14. Avera Oahe Manor was found not in compliance with the following requirement(s): F221, F280, F281, F323, and F425.	F 000	<i>Addendums noted with an asterisk per 7/11/14 telephone to facility con. JAKSDOCH/IME</i>	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, record review, policy review, and interview, the provider failed to ensure side rails, pillows, and a positioning tray had not been used as a restraint for 2 of 11 sampled residents (6 and 8). Findings include: 1. Review of resident 6's 5/26/14 Fall Follow-up form documented at 10:47 p.m. by registered nurse (RN) C revealed resident 6 had fallen. Staff had found the resident sitting on the floor by the sink. The resident had been trying to go to the bathroom. Under the heading "What can be done in the future to prevent another fall" it had been documented by RN C: *A bed alarm was pinned in place. *The resident had pulled the alarm off. *A pillow had been placed under her right side "to	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Director* (X6) DATE *7/16/14*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from if the institution provides it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disposable 30 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 30 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	<p>Continued From page 1</p> <p>prevent her from getting out of the bed." *She had still managed to get out of the bed by herself. *Two side rails had been put up on the bed. *The resident had still been able to get out of the bed. *She had recommended the resident be moved closer to the nurses station.</p> <p>Interview on 6/24/14 at 8:07 a.m. with the director of nursing (DON) confirmed: *She had not reviewed the above documentation and had not been aware of it. *RN C had restrained the resident with the use of the pillow and side rails. *Physician orders, assessments, and care planning was required before restraints could be used. *RN C had worked part time and was no longer employed at the facility. *She had not been sure if RN C had received training for the use of restraints or had read the provider's restraint policy. *She would have to check her employee file to be sure.</p> <p>Review of RN C's employee file revealed: *She had signed the Orientation Record for New Employees form on 9/11/13. *That form indicated RN C had reviewed the restraint policy. *She had signed the provider's January 2013 unnamed form on 8/27/13. -It had confirmed with her signature that she had received information on resident abuse. -It had also confirmed she had received information on the resident's bill of rights.</p> <p>Interview on 6/24/14 at 9:30 a.m. with the DON</p>	F 221	<p>Review with All Staff on 07-09-2014, the Restraint Policy & with Nursing Staff on 07-23-2014 including need for order, assessment, and care planning before use of restraints such as pillows and side rails.</p>	07-23-14

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F 221	<p>Continued From page 2</p> <p>confirmed:</p> <ul style="list-style-type: none"> *If the side rails were not removed from a bed they potentially could be used. *She had never thought of having them removed from a resident's bed. *She had not believed half side rails had needed to be assessed and care planned before being put into use for a resident or had been a restraint. *She confirmed resident 6's care plan had not addressed the use of side rails. *The Nursing policy book index had a listing for side rails. *She had been unable to find a policy for the use of side rails in the book or anywhere else. <p>Review of resident 6's most current MDS completed on 3/24/14 revealed:</p> <ul style="list-style-type: none"> *She had required limited assistance of one for transfers (moving from one surface to another) and for bed mobility (rolling from side-to-side in bed). *The resident had a Brief Interview for Mental Status (BIMs) assessment with a score of 4 out of a possible 15. *A score of 0-7 indicated severe mental impairment. <p>Observation and interview on 6/25/14 at 10:25 a.m. with the Minimum Data Set registered nurse (MDS RN) at 10:25 a.m. revealed the resident was not in her room at that time. Her bed had been made and the upper side rail was in the up position. It had been the side rail next to the wall. That side rail had bed controls that allowed the bed position to be adjusted. The MDS RN had confirmed the resident had been able to use the controls only some of the time due to her cognitive level (mental function). She also confirmed the resident's daughter refused to</p>	F 221	<p>All residents who use their half side rails will have the order, family consent, Pre-Restraining Assessment & care plan completed by 07-23-14.</p> <p><i>JASDDH/MF</i> * Side Rail Policy <i>JASDDH/MF</i> will be reviewed at Nurses Staff Meeting on 07-23-14.</p> <p>Side rails not in use will be kept down or zip-tied if not needed. An inventory of all residents & their beds are being assessed as needed. Colored stickers will be used to identify which residents can utilize bed rails, which can only be utilized for bed control use.</p>	<i>JASDDH/MF</i>

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F 221	<p>Continued From page 3</p> <p>allow the resident to be moved to a room closer to the nurse's desk. The daughter had felt it would have been too confusing for the resident.</p> <p>Review of the resident's 3/26/14 care plan last updated on 6/15/14 revealed: *She had fallen on 4/7/14 that resulted in a pelvic fracture. *She had a hip pinning on 4/17/14 after a fall. *A problem of impaired activity of daily living function "evidenced by bed mobility." *A problem of high risk for falls evidenced by a history of falls, impaired mobility, and impaired cognition. *The care plan had not addressed the use of side rails as an intervention for any of the above problems. *The use of side rails had not been addressed on the care plan.</p> <p>Review of the resident's medical record revealed no assessments for the use of side rails at any time.</p> <p>Review of resident 6's physician's orders from 4/14/14 through 6/17/14 revealed: *She had diagnoses of senile dementia, cerebral vascular accident (stroke), and hemiplegia/hemiparesis (paralysis or impairment on one side of the body). *There had been no orders for the use of side rails while in bed or the use of a pillow to keep her in bed.</p> <p>Surveyor: 32333 2. Review of resident 8's complete medical record revealed she had a diagnosis of dementia. She had been a resident in the secured unit (Haven).</p>	F 221	<p>Resident 6 has an order & assessment completed on 06-26-14 for use of back half-rail to turn self over in bed.</p>		

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F 221	<p>Continued From page 4</p> <p>Review of resident 8's 5/6/14 physician's orders revealed an order she could use a positioning tray on her wheelchair.</p> <p>Review of resident 8's 2/7/14 care plan revealed: *A high risk for falls related to impaired balance, mobility, and cognition (mental status). *A goal she would not fall and injure herself. *An intervention for a positioning tray on her wheelchair to maintain proper body alignment.</p> <p>Interview on 6/25/14 with the Minimum Data Set coordinator regarding resident 8 revealed there had been no assessment completed for the use of an enabler for correct seating with the wheelchair support positioning device.</p> <p>Interview on 6/25/14 at 7:30 a.m. with registered nurse G who was also the coordinator in the secured unit regarding resident 8 revealed: *She was unable to remove her wheelchair support positioning device upon command. *No assessment had been done for the use as an enabler for correct seating with the wheelchair support positioning device.</p> <p>Review of the provider's June 2013 Restraints Physical or Chemical policy revealed the purpose was "To ensure that rights of the patients are stringently guarded and that no restraint will be initiated unless the patient's behavior and safety clearly indicates a need / [.]"</p> <p>Surveyor: 28057 3. Review of South Dakota Department of Social Services, Adult Services and Aging, Long-Term Care Facilities, Resident's Bill of Rights pamphlet included in the provider's admission packet</p>	F 221	<p>The Restraint Initiated Intervention for resident 8 was completed on 06-26-14 for assessment to prevent resident from leaning while in wheelchair.</p>		

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F 221	Continued From page 5 revealed a resident was entitled to quality of life. It further stated a resident was to be free from physical restraints. Review of the provider's undated Resident Bill of Rights revealed residents were to be free of physical restraints unless authorized in writing by a medical provider. If authorized a specified limited time was to have been documented for the use of the restraint. Review of the provider's June 21013 Physical or Chemical Restraints policy revealed: *A consent form was to have been signed by the family before physical restraints could be used. *Written orders were required from the medical provider. *Documentation of the rationale for use of the restraint had been required.	F 221	Coordinators will complete QI study monthly x 3 to check for orders, assessment, consent & care planning of half side rails in use <input checked="" type="checkbox"/> random July, August, & September, monitored by Director of Nursing & reported to QI Committee at next meeting in September. * QI committee will determine when to stop. JA/SDDH/MF * residents for JA/SDDH/MF * Results will be JA/SDDH/MF		
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. 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	F 280			

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F 280	<p>Continued From page 6 and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, record review, interview, and policy review, the provider failed to ensure care plans for 8 of 11 sampled residents (1, 2, 3, 4, 5, 6, 8, 9, and 11) had included assessments, problems, goals, and interventions for the use of bed rails while in bed. Findings include:</p> <p>1a. Random observations from 6/23/14 through 6/25/14 revealed residents 3, 4, and 6 had side rails on their beds. Residents 3 and 6 had at least one rail up during those observations. Refer to F221, finding 1; and F323, findings 1, 3, 4, 5, and 6.</p> <p>Review of residents 3, 4, and 6's care plans revealed: *Resident 3's care plan was last completed on 6/6/14. *Resident 4's care plan was completed on 5/7/14. *Resident 6's care plan was completed on 3/26/14. *None of the above care plans addressed the use of bed rails while those residents had been in bed.</p> <p>Surveyor: 32333 b. Random observation from 6/23/14 through 6/25/14 of residents 5, 8, and 9 revealed two bed rails had been used on their beds.</p>	F 280	<p>*Residents 1, 2, 4, 5, 8, 9 and 11 have had the assessment for side rails completed. Also if a side rail is used it has been care planned. Residents 3 and 6 will be done by 7/22/14. JA/SDDH/ME</p>		

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F 280	<p>Continued From page 7</p> <p>Review of residents 5, 8, and 9's complete medical records revealed no assessments for the use of bed rails. All three residents had been in the secured unit (Haven).</p> <p>Review of of residents 5, 8, and 9's care plans revealed no mention of the use of bed rails. Refer to F323, findings 8, 9, and 10.</p> <p>Surveyor: 32572 c. Random observation from 6/23/14 through 6/25/14 of residents 1, 2, and 11 revealed two bed rails had been used on those beds.</p> <p>Review of residents 1, 2, and 11's medical records revealed no assessments for the use of those bed rails. All three residents had been in the secured unit. *Review of resident 1's 3/24/14 Minimum Data Set (MDS) revealed a Brief Interview of Mental Status (BIMS) score of six which indicated a severe cognitive (thought processes) impairment. *Review of resident 2's 4/21/14 MDS revealed a BIMS score of zero that indicated severe cognitive impairment. *Review of resident 11's 4/23/14 MDS revealed a BIMS score of 99 that indicated she was unable to be interviewed for the testing.</p> <p>Review of residents 1, 2, and 11's care plans revealed no mention of the bed rails.</p> <p>d. Interview on 6/25/14 at 1:25 p.m. with the director of nursing (DON) confirmed there was no longer a bed rail or side rail policy. It had been listed on the index of the nursing policy and procedure manual.</p> <p>Review of the provider's undated Care Planning</p>	F 280	<p>All residents with bed rails in use will have an order, assessment, consent and care plan completed by 07-23-14.</p> <p>Those residents with severe cognitive impairment will have bed rails down & not care planned for use of bed rails.</p> <p>Coordinators will complete QI study monthly x 3, July, August & September to check for orders, assessment, consent & care planning of half side rails in use</p> <p>*randomly monitored by Director of Nursing & reported to QI Committee at next meeting in September. *QI committee will determine when to stop. JAKDDH/ME</p> <p>* residents. Results will be JAKDDH/ME</p>	07-23-14

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F 280	Continued From page 8 policy revealed: *"The purpose was to develop individualized care plans for each residents according to their need, behaviors and diversions which work for them and to provide consistent day to day care." *The policy stated the care planning assessment team consisted of "nurses, nurse aides, pastoral care, restorative aides, dietary, activities, and social service personnel."	F 280		
F 281 SS=E	Refer to F323, findings 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 A. Based on observation, interview, record review, and policy review, the provider failed to ensure medications were administered safely to one of nine residents (13) by one of one unlicensed assistive personnel (UAP) A during one of six medication administration observations. Findings include: 1. Observation on 6/23/14 at 3:30 p.m. revealed the UAP A had administered fluticasone/salmeterol diskus inhaler to resident 13 when the medication administration record (MAR) revealed tiotropium bromide inhaler should have been given. The tiotropium bromide inhaler had been ordered by the physician to be given at that time.	F 281		

**UAP A has been educated by the DON regarding medication administration & rights on 7/1/14. JAL/SDOH/MF*

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F 281	Continued From page 9 Interview at that time with UAP A confirmed she realized she had administered the incorrect medication to resident 13. She had reported the error to the director of nursing (DON) and was unsure what the process was after that. Interview on 6/24/14 at 9:10 a.m. with the DON confirmed she had been aware of the above medication administration error had occurred. She confirmed the physician had been notified of the error, and specific instructions had been received. She confirmed the process was to have been notification to the physician of the error and then completion of an incident report in the electronic medical record. She confirmed she had assisted UAP A in completion of the incident report. Review of the medical record revealed no hand written physician's order by the DON. The electronic chart revealed ther had been no entries by the DON revealing new physician orders received or notification of the medication administration error. There had been a nurses note entered by UAP A on 6/23/14 at 16:04 (4:04 p.m.) which stated "Advair given provider notified." The MAR documentation revealed tiotropium bromide had been administered at 3:30 p.m. and fluticasone/salmeterol diskus administered at 0919 (9:19 a.m.) and 1913 (7:19 p.m.) There had not been any documentation the fluticasone/salmeterol diskus had been administered at 3:30 p.m. Review of the provider's undated Administration of Medication policy revealed "Check label with eMAR (electronic medication administration record) x (times) 3."	F 281	Entry of medication error into Meditech reviewed with medication aide & will be reviewed at nurses staff meeting on 07-23-14 for all nursing staff. Providers telephone order documented in nurses notes & order sheet on 06-24-14. Administration of Medications Policy reviewed with all nursing staff on 07-23-14 at Manor Nurses Staff meeting with emphasis of 6 medication rights, checking medication label x 3 when administering & documenting all medication administrations. [REDACTED] to ensure following the 6 rights, checking label x 3 & documenting correctly [REDACTED] monthly x 3 [REDACTED] by coordinators & monitored by Director of Nursing to report to QI Committee meeting in September. * QI committee will determine when to stop [REDACTED] * observations of random medication administration time will be done [REDACTED]	07-23-14

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F 281	Continued From page 10 Review of the provider's undated Medication Aide job description revealed: *"Job summary: The medication aide (UAP) is responsible for the medication administration assistance to each resident on the nursing unit when assigned by the charge nurse to perform such duties and keeps the resident's medication records current during such assignments." *"Records administrations on the appropriate medication and treatment forms." Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, Mo., 2005, revealed: *Page 419 "The physician was responsible for directing medical treatment. Nurses were obligated to follow physicians' orders unless they believed the orders were in error or would harm clients. *Page 841: revealed the six rights for medication administration were; the right medication, the right dose, the right resident, the right route, the right time, the right documentation. Surveyor: 32333 B. Based on record review and interview, the provider failed to ensure one randomly reviewed unlicensed assistive personnel (UAP) (F) had performed assessments on one of eleven sampled resident (9). Findings include: 1. Review of resident 9's complete medical record revealed: *She had a history of falls. *Her most recent fall had been on 6/16/14. *A fall report had been completed by UAP F. Review of resident 9's Neuro (neurological) Signs	F 281			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2014
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 281	<p>Continued From page 11</p> <p>Form revealed two times on 6/16/14 and once on 6/17/14 UAP F had performed and documented the resident's neurological checks.</p> <p>Interview on 6/25/14 at 9:00 a.m. with registered nurse G who was also the coordinator in the secured unit (Haven) revealed: *They had never had licensed nurses working overnights until the Department of Health identified the deficient practice on their previous survey. *The UAPs had been assessing residents and documenting those assessments. *She trusted the UAPs to assess residents and thought they could do that.</p> <p>Interview on 6/25/14 at 10:15 a.m. with the director of nursing revealed: *They had been letting their UAPs perform assessments on residents. *She agreed UAPs should not have been performing assessments on residents.</p> <p>Review of the provider's Medication Aide (UAP) job description revealed "The duties are assigned to the medication aide by the charge nurse but are within the realm of those delineated by the South Dakota Board of Nursing."</p> <p>Review of: SOUTH DAKOTA BOARD OF NURSING, SOUTH DAKOTA DEPARTMENT OF HEALTH, www.state.sd.us/doh/nursing, accessed on the internet on 6/26/14, revealed: "20:48:04.01:01. General criteria for delegation. The registered nurse is responsible for the nature and quality of nursing care that a client receives under the nurse's direction. To achieve full utilization of the services of a registered nurse or</p>	F 281			

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F 281	Continued From page 12 a licensed practical nurse, the licensed nurse may delegate selected nursing tasks to unlicensed assistive personnel. Unlicensed assistive personnel may complement the licensed nurse in the performance of nursing functions but may not substitute for the licensed nurse. Unlicensed assistive personnel may not redelegate a delegated act. A licensed nurse is accountable to practice in accordance with the scope of practice as defined in SDCL chapter 36-9. The delegating nurse is accountable for assessing a situation and making the final decision to delegate. The delegation of nursing tasks to unlicensed assistive personnel must comply with the following criteria: (1) The nursing task is one that a reasonable and prudent licensed nurse would find within the scope of sound nursing judgment to delegate; (2) The nursing task is one that, in the opinion of the delegating licensed nurse, can be properly and safely performed by unlicensed assistive personnel without jeopardizing the client's welfare; (3) The nursing task does not require unlicensed assistive personnel to exercise nursing judgment; (4) The licensed nurse evaluates the client's nursing care needs before delegating the nursing task; (5) The licensed nurse verifies that the unlicensed person is competent to perform the nursing task; and (6) The licensed nurse supervises the performance of the delegated nursing task in accordance with the requirements of §20:48:04.01:02."	F 281	<i>* Coordinators will complete</i> Delegation of Nursing task requirements will be instituted as policy & reviewed at the July 23 Nurses Staff meeting. A QI study & record review [redacted] in July, August & September to ensure only nurses, not medication aides are assessing residents after falls & completing neurological checks to be done by nurses. monitored by Director of Nursing then reported at September QI meeting. <i>* QI committee will determine when to stop.</i> <i>* The results will be</i>	
F 323 SS=F	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	<p>Continued From page 13</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Surveyor: 32572 Surveyor: 28057 Based on observation, record review, interview, manufacturer specifications, and policy review, the provider failed to ensure bed side rails had been used in a safe manner to prevent potential injury for 10 of 11 sampled residents (1, 2, 3, 4, 5, 6, 8, 9, 10, and 11). Findings include:</p> <p>1. Observation on 6/23/14 from 12:30 p.m. through 1:45 p.m. revealed many residents' beds with side rails attached to them. Some of the beds had full length rails attached to them (photos 1 and 2). Others were half rails at the head of the bed or two sets of half rails, one at the head of the bed and the other at the foot of the bed. Some of the side rails had been in the up position on one side of the bed and most of those had been at the head of the bed.</p> <p>Interview on 6/24/14 at 9:30 a.m. with the director of nursing (DON) confirmed: *There had been no process in place to ensure side rails had not been used when present on the bed.</p>	F 323	<p>All residents with bed rails in use will have care plans addressing the use of them, including half bed rails.</p> <p>The Restraint Policy and education includes half bed rails used for repositioning. Bed rails will be down or zip-tied & not used for severe cognitive impaired residents.</p> <p><i>*beds with full rails have been tied down. Residents beds that have bed controls in the side rails will remain down and used for staff only unless assessed and care planned for resident use. JA/SDDH/MF</i></p>	

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F 323	<p>Continued From page 14</p> <p>*She had never thought of removing the side rails.</p> <p>*She confirmed none of the residents' care plans had addressed the use of side rails when in bed.</p> <p>*She could not remember if there was a side rail policy.</p> <p>*She later confirmed she had been unable to find a side rail policy.</p> <p>Review of the provider's June 2013 Restraints-Physical or Chemical policy revealed half bed rails used to assist with repositioning had been excluded from the definition of restraints.</p> <p>Interview on 6/24/14 at 10:45 a.m. with the Minimum Data Set (MDS) nurse confirmed:</p> <p>*She had not care planned half upper side rails.</p> <p>*No assessments or care planning had been done in regards to use of the upper rails that had bed controls on them.</p> <p>*She had depended on the resident to have told the staff how they had wanted the side rails.</p> <p>*She had not considered them a side rail but instead a bed control.</p> <p>*She stated they had not used full rails as they were a restraint free facility.</p> <p>Observation on 6/24/14 at 10:55 a.m. revealed beds E 20 A and E 9 B had full length rails on both sides of the bed. Both of those beds were occupied by residents. The rails had not been raised but were operational and usable. Room E 16 A and B (photos 3 and 4) was unoccupied. Both beds in that room had full rails on both sides for the length of the bed.</p> <p>Interview on 6/24/14 at 1:10 p.m. with certified nursing assistant (CNA) D confirmed:</p> <p>*She would have put the side rails up if the</p>	F 323		

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F 323	<p>Continued From page 15</p> <p>resident had requested her to do so. *She would also have put them up if she had believed the resident would have fallen out of bed without the use of the side rails.</p> <p>Interview on 6/24/14 at 1:20 p.m. with CNA E confirmed: *She would have put the side rails up if the resident had requested her to do so. *She would have checked with the nurse if she had been unsure. *She had believed the use of the half upper rails was not considered a restraint.</p> <p>Surveyor: 32333 2. Random observations of the secured unit (Haven) from 6/23/14 through 6/25/14 revealed: a. Resident 5 had two half bed rails at the head of her bed.</p> <p>Review of resident 5's complete medical record revealed she: *Had been admitted on 3/3/14. *Had a diagnosis of dementia. *Was a resident in the secured unit (Haven). *Had a severely impaired cognitive (mental) status. *Had a history of a fall. *Had no assessment for the use of her bed rails.</p> <p>Review of resident 5's care plan revealed no mention of the use of bed rails.</p> <p>b. Resident 8 had two half bed rails at the head of her bed.</p> <p>Review of resident 8's complete medical record revealed she: *Had been admitted on 3/7/11.</p>	F 323		

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F 323	<p>Continued From page 16</p> <ul style="list-style-type: none"> *Had a diagnosis of dementia. *Was a resident in the secured unit. *Had a severely impaired cognitive status. *Had a history of falls. *Had no assessment for the use of her bed rails. <p>Review of resident 8's care plan revealed no mention of the use of bed rails.</p> <p>c. Resident 9 had two half bed rails on the head of her bed.</p> <p>Review of resident 9's complete medical record revealed she:</p> <ul style="list-style-type: none"> *Had been admitted on 10/15/10. *Had a diagnosis of dementia. *Was a resident in the secured unit. *Had a severely impaired cognitive status. *Had a history of falls. *Had no assessment for the use of her bed rails. <p>Review of resident 9's care plan revealed no mention of the use of bed rails.</p> <p>Surveyor: 32572</p> <p>d. Resident 1 had two half bed rails up on the head of her bed.</p> <p>Review of resident 1's medical record revealed she:</p> <ul style="list-style-type: none"> *Had been admitted on 4/5/12. *Had a diagnosis of dementia. *Was a resident in the secured unit. *Had a severely impaired cognitive status. *Had no assessment for the use of the bed rails. <p>Review of resident 1's care plan revealed no mention of the use of bed rails.</p>	F 323		

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F 323	Continued From page 17 e. Resident 2 had two half bed rails up on the head of her bed. Review of resident 2's medical record revealed she: *Had been admitted on 1/16/13. *Had a diagnosis of dementia. *Was a resident in the secured unit. *Had a severely impaired cognitive status. *Had no assessment for the use of her bed rails. Review of resident 2's care plan revealed no mention of the use of bed rails. f. Resident 10 had two full bed rails on her bed. Review of resident 10's medical record revealed she: *Had been admitted on 5/28/14. *Had a diagnosis of senility without psychosis (loss of contact with reality) and delusional (false belief) disorder. *Had a moderately impaired cognitive status. *Had no assessment for the use of her bed rails. Review of resident 10's care plan revealed no mention of the use of bed rails. g. Resident 11 had two half bed rails up on the head of her bed. Review of resident 11's medical record revealed she: *Had been admitted on 11/21/05. *Had a diagnosis of dementia. *Was a resident in the secured unit. *Had a severely impaired cognitive status. *Had no assessment for the use of her bed rails.	F 323		

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F 323	<p>Continued From page 18</p> <p>Review of resident 11's care plan revealed no mention of the use of bed rails.</p> <p>Surveyor: 28057</p> <p>3a. Observation and interview on 6/25/14 at 7:55 a.m. with the maintenance supervisor confirmed the beds in E 20 A and 16 B were Kimball Health Care Company beds. He had no manufacturer user manuals for those types of beds. Some of the residents beds were Hill-Rom beds. He had supplied the user manual for the Hill-Rom beds in use.</p> <p>Review of the undated user manual for the Hill-ROM Resident LTC (long term care) Bed revealed:</p> <ul style="list-style-type: none"> *A warning to evaluate patients (residents) for entrapment (becoming caught or tangled) risk when side rails were used. *Side rails were intended as a reminder of the bed edges not as a restraint. *A caution when using mattresses that were not sold by Hill-Rom on those beds. *The recommended dimensions for the mattress was a width of 36-37 inches and 5-6 inches in depth. *Use of mattresses that were not sold by Hill-Rom could reduce the safety features and systems of those beds. <p>b. Observation and interview on 6/25/14 at 10:25 a.m. with the MDS nurse confirmed:</p> <ul style="list-style-type: none"> *Resident 6's bed frame was a Hill-Rom bed (photos 5 and 6). *It had a Medline/Medcrest Odyssey Zero G mattress on the bed (photo 7). *That mattress measured 34.5 to 35 inches in width. 	F 323	<p>To ensure that residents are free of hazards.</p> <ol style="list-style-type: none"> 1. Completed bed/mattress inventory.(See attached sheet) 2. All beds with full rails will be zip-tied down so they are out of use as of 07-17-14. 3. If the resident has half rail up, it will have proper assessments & documentation as stated in F221. 4. If bed rail is not care planned for, they will be in down position unless staff needs them for bed control. Bed rail would then be returned to down position. 5. To prevent entrapment, all Hill-Rom beds will have current mattresses replaced with Hill-Rom mattresses that meet manufacturers recommendations that fit current sleep decks of 36 x 80. 6. Environmental Services coordinator will be in charge of ordering correct products going forward. (Currently need 15 regular mattresses & 9 concave mattresses) <p>A QI study [redacted] in July, August, & September to monitor for correct side rail use & report to QI Committee in September. *QI committee will determine when to stop. JATSDDCHIME</p> <p>*Resident care Director will perform a JATSDDCHIME</p> <p style="text-align: right;">07-23-14</p>

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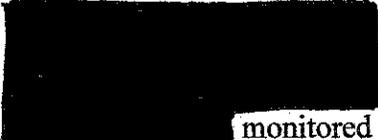
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F 323	<p>Continued From page 19</p> <p>*It had measured 6 inches deep. *The manufacturer had required 36-37 inches width for a mattress when used on that bed. *That mattress had allowed more space between the mattress and the side rails when in-use. *The upper rail against the wall had been in-use and was in the up position at that time.</p> <p>Review of resident 6's care plan completed on 3/26/14 revealed the use of side rails while in bed had not been addressed.</p> <p>4. Observation and interview on 6/25/14 at 10:25 a.m. with the MDS nurse confirmed: *Resident 3's bed frame was a Hill-Rom bed. *It had a Medline/Medcrest Odyssey Zero G mattress on the bed. *That mattress measured 34.5 to 35 inches in width. *It had measured 6 inches deep. *The manufacturer had required 36-37 inches width for a mattress when used on that bed. *That mattress had allowed more space between the mattress and the side rails when in use. *The upper rail against the wall had been in use and was in the up position at that time.</p> <p>Review of resident 3's care plan completed on 6/6/14 revealed the use of side rails while in bed had not been addressed.</p> <p>5. Observation on 6/25/14 at 9:35 a.m. revealed: *Resident 4's bed frame was a Hill-Rom bed. *The bed had upper rails installed on the bed.</p> <p>Review of resident 4's care plan completed on 5/7/14 revealed the use of side rails while in bed had not been addressed.</p>	F 323		

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F 425 F 425 SS=D	Continued From page 20 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation and interview, the provider failed to ensure medications delivered to the provider had been secured during one of one observation. Findings include: 1. Observation on 6/23/14 at 5:25 p.m. revealed: *An unidentified person handed an unidentified certified nursing assistant (CNA) who had been sitting at the nurses station a white paper bag. *The CNA placed that bag off to her left side and behind her on the counter at the nurses station.	F 425 F 425		

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F 425	<p>Continued From page 21</p> <p>She then left the nurses station and left the bag unattended.</p> <p>*At 5:35 p.m. the social service designee (SSD) had noted the bag on the counter and notified the charge nurse of the delivered bag.</p> <p>*At 5:38 the charge nurse placed the bag in the locked medication room. During that time frame there had been numerous residents and families in the area of the nurses station.</p> <p>*The bag revealed a medication card with thirty tablets of lorazepam (medication for anxiety and is highly diverted [stolen]) 0.5 milligrams (mg) for one of the residents.</p> <p>Interview on 6/23/14 at 5:35 p.m. with the SSD confirmed the pharmacy delivery person was to have delivered the medications to the charge nurse and not to a CNA.</p> <p>Interview on 6/24/14 at 10:15 a.m. with the director of nursing confirmed the pharmacy should have delivered the medication bag to the charge nurse. She also confirmed that had not been the first time that had occurred with this pharmacy.</p> <p>The provider did not have a policy for obtaining medications and who the medications should have been delivered to upon arrival to the provider.</p>	F 425	<p>Conversation with Long Term Care Vilas Pharmacy about delivery of medications to Manor. He said a temporary courier was used that week & they have been instructed to deliver only to a nurse. Review of Medication Delivery Policy at Nurses Staff meeting on 07-23-14.</p> <p> monitored by Director of Nursing to be reported at September QI meeting.</p> <p>*QI committee will determine when to stop. JASDDH/MF</p> <p>*The East Hall nurse will complete a QI study of couriers on random days of the month in July, August, and September. The results will be JASDDH/MF</p>	7/23/14

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K 000 INITIAL COMMENTS

Surveyor: 32334
A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 06/24/14. Avera Oahe Manor was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.

The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K027, K029, and K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.

K 027 NFPA 101 LIFE SAFETY CODE STANDARD

SS=D

Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7

This STANDARD is not met as evidenced by:
Surveyor: 32334
Based on observation, testing, and interview, the provider failed to maintain self-closing smoke barrier doors on one of three sets of smoke barrier doors (into the south wing). Findings include:

K 000

Addendums noted with an asterisk per 7/16/14 telephone to facility administrator. LF/SDDOH/IMF

K 027

Maintenance staff tightened up the top of the door frame. Barrier doors now self-close. Maintenance staff also inspected all other barrier doors within Long Term Care. All self-close. Reviewed by Director of Fiscal Services/Human Resources.

07-14-14

*Maintenance staff will monitor the doors weekly for 3 months & will be verified by the Director of Fiscal Services/Human Resources and will be reported to the AI committee by the same Director. LF/SDDOH/IMF

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

Mark Schmitt

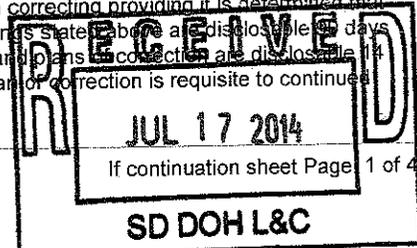
TITLE

Executive Director

(X6) DATE

7/16/14

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 30 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2014
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	Continued From page 1	K 027		
K 029 SS=E	<p>1. Observation at 10:20 a.m. on 6/24/14 revealed a set of cross-corridor smoke barrier doors on the south wing. Testing of those doors revealed the west leaf would bind on the top of the door frame and would not close into its frame. It would not be capable of resisting the passage of smoke. Interview with the maintenance supervisor at the time of observation and testing confirmed that condition.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain proper separation of hazardous areas in two randomly observed areas (air handler room and storage room both in the secure unit). Findings include:</p> <p>1. Observation at 10:45 a.m. on 6/24/14 revealed an air handler room in the secure unit. That room was over 50 square feet and was being used to</p>	K 029	<p>* Maintenance staff will monitor the doors weekly for 3 months and will be verified by the Director of Fiscal Services/Human Resource and will then be reported to the AI committee by the same Director. JAS/SDH/MT</p>	

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K 029	Continued From page 2 store combustible materials. That room would classify as a hazardous area. The door to that room was capable of resisting smoke but was not provided with a self-closing device. Interview with maintenance supervisor at the time of observation confirmed that condition. 2. Observation at 10:55 a.m. on 6/24/14 revealed a storage room near the entrance to the secure unit. That room was over 50 square feet and was being used to store combustible materials. That room would classify as a hazardous area. The door to that room was provided with self-closing hinges but those hinges were not capable of closing the door into the frame. Interview with the maintenance supervisor at the time of observation confirmed that finding.	K 029	1. Maintenance staff installed a door closure mechanism allowing the door to self-close. 2. Maintenance staff installed a door closure mechanism, door now closes tightly into the frame. Both doors were reviewed by Director of Fiscal Services/Human Resource.	07-15-14
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on record review and interview, the provider failed to ensure the automatic sprinkler system had required quarterly flow testing performed during the previous twelve months. Findings include: 1. Review of the provider's automatic sprinkler system inspection reports revealed quarterly flow testing documentation was not available.	K 062	Building Sprinkler will be on-site July 21, 2014 to train maintenance staff on [REDACTED] on our wet and dry sprinkler system. <i>* all inspections, testing & maintenance requirement LEADSDHIME</i>	07-23-14

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K 062	Continued From page 3 Interview with the maintenance director at the time of the record review indicated he was unaware of all the quarterly flow testing requirements. Further interview revealed some of the quarterly flow testing for the wet system was being performed but was not being documented. He further stated he was not aware of the quarterly testing requirements for the dry system.	K 062	This will be monitored quarterly x 2 and reported to the QI Committee. Will be reviewed by the Director of Fiscal Services/Human Resources.		

ORIGINAL

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FORM APPROVED

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10624	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2014
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NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST GARFIELD AVENUE GETTYSBURG, SD 57442
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S 000	Initial Comments Surveyor: 32572 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 6/23/14 through 6/25/14. Avera Oahe Manor was found not in compliance with the following requirement(s): S127, S166, and S206.	S 000	Addendums noted with an asterisk per 7/14/14 telephone to facility DON. JALSDDH/MF	
S 127	44:04:02:05 HOUSEKEEPING CLEANING Written housekeeping procedures must be established for the cleaning of all areas in the facility and copies made available to all housekeeping personnel. All parts of the facility must be kept clean, neat, and free of visible soil, litter, and rubbish. Equipment and supplies must be provided for cleaning of all surfaces. Such equipment must be maintained in a safe, sanitary condition. Hazardous cleaning solutions, chemicals, poisons, and substances shall be labeled, stored in a safe place, and kept in an enclosed section separate from other cleaning materials. Cleaning of areas designed for...resident use must be performed by dustless methods which will minimize the spread of pathogenic organisms in the facility's atmosphere. All vacuums used in medical facilities...must be equipped to provide effective discharge air filtration of particles larger than 0.3 microns. Cleaning must include all environmental surfaces within the facility that are subject to contamination from dust, direct splash, or pathogenic organisms except medical equipment, supplies, or devices that are the responsibility of other services or departments of the facility.	S 127	*Housekeeper K and Housekeeping supervisor were educated on security of chemicals of housekeeping cart on 7/14/14 by the Director of Resident Care. JALSDDH/MF	

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

STATE FORM 021199 2BOL11

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JUL 17 2014
SD DOH L&C

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 127	Continued From Page 1 This Rule is not met as evidenced by: Surveyor: 28057 Based on observation, interview, and policy review, the provider failed to secure chemicals on one of one randomly observed housekeeping cart when unattended in the hallway. Findings include: 1. Observation on 6/25/14 at 9:40 a.m. revealed a housekeeping cart unattended in the hallway (photo 8). Observation and interview on 6/25/14 at 1:50 p.m. confirmed a housekeeping cart was located in the south hallway (photo 9). No staff had been in sight of the cart initially. Toilet bowl cleaners and disinfectants had been on the open cart. When housekeeper K and the housekeeping supervisor came out into the hallway they had confirmed there had been no way to secure the chemicals on the cart. They stated when they cleaned they had tried to keep the cart in sight as much as possible. They confirmed that had not always been possible, especially when they had been cleaning a resident's bathroom. Review of the provider's 7/1/13 Chemicals Used for General Cleaning policy revealed all cleaning chemicals were to have been kept in a locked storage unit.	S 127	To secure chemicals on the housekeeping carts: 1. Current carts will be replaced with carts that have lockable doors to properly secure chemicals. 2. New carts ordered 07-15-14. * [REDACTED] JALSDDOH/ME 3. Until new carts arrive, existing carts/chemicals will not be unsupervised. * [REDACTED] JALSDDOH/ME * The [REDACTED] Director of Resident Services* Report to Qi Committee in September. * The Director of Resident Services will [REDACTED] JALSDDOH/ME * Qi committee will determine when to stop. JALSDDOH/ME will monitor the housekeeping carts at random times during the day for security of chemicals until the new carts arrive. When the new carts arrive the monitoring will be completed monthly for 3 months. JALSDDOH/ME	07-23-14
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	S 166		

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S 166	Continued From Page 2 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 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. This Rule is not met as evidenced by: Surveyor: 28057 Based on observation, interview, testing, and	S 166		

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S 166	<p>Continued From Page 3</p> <p>policy review, the provider failed to ensure one of six exit doors (the west door to the clinic) had an activated audible alarm or was attended at all times. Findings include:</p> <p>1. Random observations and testing of the west door to the clinic from 6/23/14 through 6/25/14 revealed:</p> <ul style="list-style-type: none"> *The door remained unalarmed from 7:00 a.m. through 5:00 p.m. *No alarm had sounded when the door had been opened during those times. *Staff had not always been in sight of the door (photo 8). *The director of nursing's (DON) office was located in that hallway. *The dietary manager's office was located in that hallway. *Even with those office doors open you could not see the west door to the clinic. *The nurse's desk was located at the other end of that hallway. <p>-When seated at that desk you could not see the west door.</p> <p>Interview on 6/25/14 at 9:35 a.m. with the DON confirmed the west door to the clinic was not alarmed during the day. It was turned on every evening and off again in the morning. She was not sure of the exact times it was turned on and off everyday. She agreed it was not always in sight of staff during the times it was turned off during the day.</p> <p>Interview on 6/25/14 at 10:55 a.m. with the DON confirmed she came to work at 8:30 a.m. and left at 5:00 p.m. everyday.</p> <p>Interview on 6/25/14 at 10:57 a.m. with the dietary manager confirmed she had come to work at 7:00 a.m. and left at 3:30 p.m. Usually</p>	S 166	<p><i>*Nursing staff will be educated on 7/23/14 of new door alarm policy. JAS/DDDH/MF</i></p> <p><i>* [REDACTED] JAS/DDDH/MF</i></p> <p>The west door identified will be alarmed from 5:00 pm to 8:00 am Monday-Friday except holidays and weekends, when the door will be alarmed 24 hours/day due to limited staff in the corridor. Monitor will be completed by Director of Nursing weekly for the months of August and September and reported to QI Committee.</p> <p><i>* [REDACTED] JAS/DDDH/MF</i></p> <p><i>* QI committee will determine when to stop. JAS/DDDH/MF</i></p>	07-23-14
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S 166	Continued From Page 4 about one day per week she had come to work at 11:30 a.m. and left at 8:00 p.m. Interview on 6/25/14 at 10:45 a.m. with license practical nurse L confirmed the alarm was turned off about 6:00 a.m. and on about 6:00 p.m. Review of the provider's April 2012 Door Alarms policy revealed: *The night nurse had been responsible to turn the door alarms on and off everyday. *They were to be turned off at 5:00 a.m. and back on at 11:00 p.m. Based on the above interviews and policy review no staff were in an office in that hallway routinely from 6:00 a.m. until 7:00 a.m. and from 5:00 p.m. until 6:00 p.m. everyday when the above door had been unlocked.	S 166		
S 206	44:04:04:05 PERSONNEL-TRAINING The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory	S 206	<i>* Staff J received education on 7/9/14 on the topic of restraints. Staff H and I have received written education on restraints. JALSDDCH/MF</i> Education on restraints was given by the Director of Nursing at the July 9 th , 2014 All Staff meeting. This education material was made available to those employees who were unable to attend this meeting. x [REDACTED] JALSDDCH/MF	

