

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

ORIGINAL

PRINTED: 07/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MADISON	STREET ADDRESS, CITY, STATE, ZIP CODE 718 NE 8TH ST MADISON, SD 57042
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p><i>Additional notes with an asterisk per provider telephone to facility administrator. KES/DDH/MF</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 32335 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/7/14 through 7/9/14. Golden LivingCenter - Madison was found not in compliance with the following requirement(s): F250, F280, F281, F314, F327, F333, F334, F371, and F441.</p>	F 000	<p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p>	
F 250 SS=D	<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: 32335 Based on record review, interview, job description review, and policy review, the provider failed to assist one of one sampled resident (2) with discharge plans to find placement closer to friends and family resulting in an elopement (leaving the facility without staff knowledge) from the facility. Findings include:</p> <p>1. Review of resident 2's medical record revealed: *An admission date of 1/5/13. *Initial plans were to discharge her to her apartment to be closer to friends and family. *On 3/28/13 she had agreed to a placement in a nursing home in Sioux Falls instead of discharging to her apartment.</p>	F 250	<p>F250</p> <p>1. Referrals to facilities closer to friends and family in Sioux Falls are being actively made and followed up on for resident 2.</p> <p>Resident 2 has been interviewed to clarify discharge goals and her care plan updated to reflect.</p> <p>Licensed Social Worker (LSW) has been educated regarding resident specific discharge planning.</p> <p>2. All residents have the potential to be affected.</p>	8/22/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director	(X6) DATE 8/15/14
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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 and plans of correction are disclosed 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 disclosed 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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AUG 07 2014

If continuation sheet Page 1 of 36

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F 250	<p>Continued From page 1</p> <p>*From 3/28/13 through 6/21/13 five nursing homes had been contacted. *One of those five homes was unable to accept her but stated they might reconsider. *That nursing home had not been contacted again. *From 6/21/13 through 10/1/13 there had been no nursing homes contacted for placement. *On 9/28/13 and on 10/10/13 resident 2 had eloped from the building to go home to Sioux Falls.</p> <p>Interview and record review on 7/9/14 at 10:15 a.m. with the social services coordinator regarding resident 2's discharge planning revealed she had not: *Made any calls to nursing homes from 6/21/13 through 10/1/13. *Made any calls to nursing homes after 10/4/13. *Followed-up on any of the eleven calls she had placed to the nursing homes beginning on 3/28/13 until 5/23/14. *Contacted all the nursing homes surrounding Sioux Falls. *Consulted with the resident to identify how far outside of Sioux Falls she was willing to live. *Updated the care plan to reflect the current goals and interventions.</p> <p>Review of the provider's October 2009 Discharge Plan policy revealed: **"When the interdisciplinary team determines that a resident has potential for discharge in the next ninety (90) [days], social services staff will address the following: -Mental and/or psychosocial barriers to discharge. -Necessary supportive relationship in the community to meet his/her emotional needs.</p>	F 250	<p>3. Interdisciplinary team (IDT) has been provided education regarding meeting with residents on admission and quarterly thereafter as well as PRN to update resident plans and goals for discharge.</p> <p>4. ED/Designee will audit 4 discharge care plans weekly x 4 weeks then monthly x 3 months to ensure care plans address residents discharge goals. results of these audits will be presented to monthly Quality Assurance & Process Improvement (QAPI) Committee for review and recommendation.</p> <p><i>*by the Executive Director/Designee KJDDH/MF</i></p>	

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F 250	Continued From page 2 -The cost of needed services and financial resources necessary to pay for services. -Education needed by resident/family about available community resources and how to access those services. -Needs for emotional support to assist in adjustment to the new living environment." Review of the provider's social services coordinator job description revealed the general purpose was to "Identify and provide for each resident's social, emotional and psychological needs, and the continuing development of the resident's full potential during his/her stay at the facility and to assist in the planning of his/her discharge."	F 250			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 1. Discharge care plan has been updated for resident 2. Dialysis care plan has been updated for resident 2. Discharge care plan has been updated for resident 10. 2. All residents have the potential to be affected. 3. Nursing staff and IDT will be provided education regarding the need for each resident to have a comprehensive individualized plan of care.	8/22/14	

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F 280	Continued From page 3 This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to revise and update care plans for 2 of 13 sampled residents (2 and 10). Findings include: 1. Review of resident 2's care plan printed on 2/5/14 revealed: *A discharge goal with the following interventions: -"Placement in facilities close to Sioux Falls has been unsuccessful. Remains on wait lists. Calls placed to Garretson, Dell Rapids, and other SNF's [skilled nursing facilities] that have denied admission." -"Resident plans to return to her apartment." *A focus area regarding her kidney function with the following interventions: -"Observe for post-dialysis hang over." -"Resident specific dialysis schedule. Notify physician and dialysis center if unable to make appointment." -"Written communication form with review of weights and any changes in condition between dialysis provider and living center." Interview on 7/9/14 at 10:15 a.m. with the social services coordinator regarding resident 2's discharge plan revealed her current discharge goal was to be discharged to another nursing home not to her apartment. She had been responsible for updating that section of the care plan. Interview on 7/9/14 at 11:00 a.m. with the director	F 280	4. DNS/Designee will audit 4 care plans weekly x 4 and monthly x 3 months to ensure care plans are comprehensive and individualized. The results of these audits will be presented to the monthly QAPI Committee for review and recommendation. <i>*by the Director Nursing Services Designee</i> <i>KG/DDDH/MF</i>		

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F 280	Continued From page 4 of nursing (DON) regarding resident 2's care plan goals revealed she was not planning on returning to her apartment, and she was not receiving dialysis. Neither of those interventions were correct on the care plan. She had not known why the care plan had not been updated. 2. Review of resident 10's care plan printed on 7/7/14 revealed: *An admission date of 6/16/14. *A focus area to discharge to a private home with home health services. *A focus area to do independent activities, because she planned to only be there a short period of time. Review of resident 10's 6/17/14 discharge assessment revealed discharge was not anticipated within the next ninety days. Long term care placement was planned for at least six months per the power of attorney. Interview on 7/9/14 at 11:00 a.m. with the DON revealed resident 10 was not planning on discharging to her home, and the care plan had not reflected that.	F 280			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281			

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F 281	Continued From page 5 This REQUIREMENT is not met as evidenced by: Surveyor: 33265 A. Based on interview, record review, and policy review, the provider failed to document the clarification of physicians' orders for medications on two of ten reviewed residents (18 and 20) physician order summaries. Findings include: 1. Review of resident 18's complete medical record revealed: *A physician's order for Ropinirole hydrochloride (medication for restless leg syndrome) on the order review report dated and signed by the physician on 7/7/14. *Instructions for that medication were for one milligram (mg) "tablet by mouth." *No instructions as to how often that medication was to be given were included with the order. Interview with licensed practical nurse (LPN) A on 7/8/14 at 8:30 a.m. revealed the instructions on the computer program directed her to give that medication three times a day. 2. Review of resident 20's completed medical record revealed: *Physician's orders dated 5/26/14 and signed 5/27/14 for: -Ducosate sodium senna (medication to loosen stools) 8.6-50 mg, instructions were for "one tablet by mouth." -Calcium 500/D (calcium and vitamin D) 500-200 mg; instructions were "tablet by mouth." -No instructions as to how often to give either medication were included in the orders. Interview with LPN I on 7/8/14 at 3:15 p.m.	F 281	F 281 A. 1. The correct report with detailed instructions were printed and signed by MD for residents 18 & 20. The calcium order for resident 20 will be clarified with MD by 8/22/14. The order summary reports for all residents will be audited by 8/22/14 to assure that there is documentation of clarification of physicians orders for medications. 2. All resident have the potential to be affected. 3. Licensed staff will be provided education regarding printing the report titled "Order Summary" that prints detailed instructions for MD Order reviews. 4. DNS/Designee will audit 4 physician order summaries weekly x 4 weeks and monthly x 3 months to ensure frequency of administration is stated as part of the medication orders. The results of these audits will be presented to monthly QAPI Committee for review and recommendation. <i>by the Director Nursing Services/ Designee</i> <i>K45DDCH/ME</i>	8/22/14	

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F 281	<p>Continued From page 6</p> <p>revealed instructions on the computer program directed her to give:</p> <p>*Ducosate sodium once a day.</p> <p>*Calcium 600/D (a different amount than the physician order signed on 5/27/14) was to be given twice a day.</p> <p>-The date the order was written according to the computer program was 6/4/14 not 5/26/14 or 5/27/14.</p> <p>-No documentation of a medication order for calcium 600/D written on 6/4/14 was found.</p> <p>Interview with the director of nursing (DON) on 7/9/14 at 2:05 p.m. revealed she:</p> <p>*Had no idea why the physicians' orders did not identify how often to give the medications.</p> <p>*Had no explanation for the difference in orders between what was on the written physicians' order review report and what was on the medication administration computer program.</p> <p>*Agreed there was no documentation of the clarification of the incomplete physicians' medication orders.</p> <p>*Would print out a copy of the medication administration instructions from the computer program.</p> <p>-Those copies were not received by this surveyor.</p> <p>Review of the provider's October 2007 Prescriber Medication Orders policy revealed:</p> <p>*Medication orders should include time or frequency of administration.</p> <p>*Any order that was inappropriate should have been verified with the physician who had prescribed the medication.</p> <p>Review of Ruth F. Craven and Constance J. Hirnle, Fundamentals of Nursing, 6th Ed., Philadelphia, Pa., 2009, p. 502, revealed the</p>	F 281	<p>B.</p> <p>1. The medication containers that had not been dated when initially opened for use were immediately disposed of.</p> <p>2. All residents have the potential to be affected.</p> <p>3. Licensed staff will be provided education regarding labeling Medication containers with open date.</p> <p>4. DNS/Designee will audit med carts weekly x 4 weeks and monthly x 3 months to ensure medications are labeled with date opened. The results of these audits will be presented to monthly QAPI Committee for review and recommendation.</p> <p><i>*by the Director Nursing Services/ Designee KBT/0000HMF</i></p>		

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F 281	<p>Continued From page 7</p> <p>nurse should always clarify with the prescriber any medication order that was unclear or seemed inappropriate and documented the results of that conversation.</p> <p>B. Based on observation, interview, and policy review, the provider failed to follow their policy for dating medication containers when opened for use. Findings include:</p> <p>1. Observation on 7/9/14 at 9:45 a.m. of the C wing medication cart revealed medication containers that had not had the date when they were initially opened for use written on the container. Multiple containers of stock (bulk) medication and three individual prescription medications were found without the opened date on the container in that cart.</p> <p>Interview on 7/9/14 at 9:50 a.m. with LPN H revealed she agreed the medication containers should have had the date when they were initially opened for use written on the container.</p> <p>Interview on 7/9/14 at 10:10 a.m. with the DON revealed she agreed the medication containers should have had the date when they were initially opened for use written on the container.</p> <p>Review of the provider's October 2007 Use of Supplied Floor Stock Medications policy revealed the floor stock medication would outdate on the expiration date on the original container or in one years time from the initial date of opening, whichever came first.</p> <p>Review of Ruth F. Craven and Constance J. Hirnle, Fundamentals of Nursing, 6th Ed., Philadelphia, Pa., 2009, p. 504, revealed the</p>	F 281		

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F 314	<p>Continued From page 9</p> <p>by the registered nurse assessment coordinator (RNAC).</p> <p>*On 6/18/14 the above pressure ulcer had been documented as healed.</p> <p>*On 7/8/14 she had acquired another stage II pressure ulcer to her right heel.</p> <p>*The RNAC monitored her wounds weekly and had been informed by the charge nurse on 7/8/14 of the newly acquired pressure ulcer to her right heel.</p> <p>*She had weekly skin checks by the charge nurse on Wednesdays.</p> <p>Observation on 7/8/14 at 6:25 p.m. of resident 5 revealed she had been resting in her recliner. Her feet had been elevated with a Prevalon boot (pressure relieving boot) on her right foot. No pressure relieving air mattress had been noted on her bed.</p> <p>Review of resident 5's 6/16/14 annual Minimum Data Set assessment revealed she had been at risk for pressures ulcers. She had required extensive assistance with bed mobility, but there was no turning/repositioning program in place.</p> <p>Review of resident 5's 11/22/13 and 5/16/14 Braden scale (assessment to determine risk level for skin breakdown) revealed:</p> <p>*She had been chairfast with limited ability to change positions independently. She had required staff support to make frequent or significant mobility changes.</p> <p>*Complete lifting without causing friction and shearing against the sheets had been impossible.</p> <p>*Her total score had been 15 placing her at risk for pressure ulcers.</p> <p>Review of resident 5's 6/18/13 care plan</p>	F 314			

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F 314	<p>Continued From page 10 revealed:</p> <p>*A focus area of "At risk for pressure ulcer due to: Assistance required with bed mobility, obesity." *An intervention area with the following plans and approaches in place: -"Turning and repositioning schedule per facility protocol." -"Provide pressure reduction/relieving mattress." -On 11/7/13 she had acquired a stage II pressure ulcer which became unstageable (unable to visualize the depth of the wound bed) on 4/17/14 and was healed on 6/18/14. -On 3/13/14 "Prevalon boot (pressure relieving boot) on right foot while in bed." -On 5/7/14 & 7/8/14 "Prevalon boot to right foot at all times except for transfers." -On 7/8/14 she had acquired another stage II pressure ulcer to her right heel. An alternating pressure system air mattress had been placed on her bed. *No interventions to support her heels or that her heels should have been floated (elevated in some manner to relieve pressure while in bed) since 6/18/13.</p> <p>Review of resident 5's 10/24/13 through 6/25/14 weekly skin assessment progress notes revealed she had: *A pressure reducing mattress and was to have worn a Prevalon boot to her right foot at all times. *Required staff support to meet all mobility, transfer, and activity of daily living needs. *Required the staff to reposition while laying in her bed as she could not offload (relieve pressure) by herself. *A history of kicking off the Prevalon boot.</p> <p>Review of resident 5's 10/24/13 through 7/8/14 nurses' progress notes revealed:</p>	F 314			

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F 314	<p>Continued From page 11</p> <p>*No documentation to support: -The staff monitoring for the placement of the Prevalon boot, and the use of any repositioning devices while she had been resting in her bed. -She had removed the Prevalon boot while resting in her bed. -She had been repositioned every two hours. -Her heels had been floated while in bed.</p> <p>Interview on 7/8/14 at 8:45 a.m. with licensed practical nurse (LPN) A regarding resident 5 revealed: *She had a history of pressure ulcers and had re-acquired a wound to her right heel during the night. She had been rubbing her heel on the sheet and mattress. *She had a history of a pressure ulcer to her right heel in October 2013, and it was healed in June 2014. *Both of the pressure ulcers had been acquired while she was a resident in the facility.</p> <p>Observation on 7/9/14 from 6:30 a.m. through 8:50 a.m. of resident 5 revealed: *She had been resting in bed and lying on her left side. *She had slid down in the bed with her knees bent. *Her heels had not been floated and were lying directly on the mattress. *She had no special devices in her bed to assist with pressure relieving measures for floating her heels and for repositioning such as pillows or foam wedges. *The Prevalon boot was laying on her recliner and was supposed to be on when she was in bed.</p> <p>Interview on 7/9/14 at 10:10 a.m. with certified nursing assistant (CNA) B regarding resident 5</p>	F 314		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MADISON			STREET ADDRESS, CITY, STATE, ZIP CODE 718 NE 8TH ST MADISON, SD 57042		
(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 314	<p>Continued From page 12 revealed:</p> <p>*She was not aware the resident should have worn the Prevalon boot while she was resting in bed.</p> <p>*She was to have been repositioned every two hours. That had been a house protocol for anyone who had required assistance with bed mobility.</p> <p>*She had not been aware of any special devices that should have been used for the resident while she was resting in bed to help with relieving any pressure areas.</p> <p>*The air mattress had just been placed on her bed yesterday (7/8/14).</p> <p>Interview on 7/9/14 at 11:10 a.m. with the director of nursing revealed:</p> <p>*The resident care plans had been in binders at the nurses' station.</p> <p>*All staff were able to access and review them.</p> <p>*She had no explanation as to why the air flow mattress had not been provided sooner then 7/8/14 for resident 5.</p> <p>*Resident 5:</p> <ul style="list-style-type: none"> -Should have worn the Prevalon boot at all times except during transfers. -Should have been repositioned every two hours per house protocol. -Should have had special repositioning devices to assist her with positioning and offloading while resting in bed. <p>*There had been no documentation requirements for the staff on repositioning of the residents.</p> <p>*She had no documentation to support resident 5 had been repositioned every two hours.</p> <p>*She had no system in place to ensure the residents requiring assistance with repositioning had been repositioned according to their house protocol.</p>	F 314			

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F 314	Continued From page 13 *The charge nurses had been expected to do visual checks for proper repositioning during their shift. Interview on 7/9/14 at 2:15 p.m. with the RNAC regarding repositioning of the residents revealed she had not supported the need for repositioning on any of the residents' MDS assessments. The provider had no system in place to support the repositioning schedules had been followed. Review of the provider's June 2014 Skin Integrity Guideline policy revealed: **"Purpose: To decrease pressure ulcer formation by identifying those residents how are at risk and developing interventions." **"Pressure redistribution mattresses are in place as indicated by the individualized plan of care." **"Initiate positioning schedule to meet individual resident needs and minimize concentrated pressure to skin as indicated by the individualized care plan." **"Positioning devices such as pillows or foam wedges are recommended to keep bony prominences (bone is below the skin surface) from direct contact with one another." **"Minimal linen under prone (areas of the skin are easily injured) skin areas and per the individualized plan of care." **"Visual observation that physical interventions are in place." Review of the provider's 2011 MicroAir User manual revealed no recommendations to reposition residents while resting on that mattress or to utilize repositioning devices.	F 314			
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION	F 327			

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F 327	<p>Continued From page 14</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335</p> <p>Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to: *Monitor oral intake, revise the resident's care plan, and follow a physician's order for one of one sampled resident (1) with a history of dehydration resulting in the potential for further dehydration. *Monitor oral intake for one of one sampled resident (2) with a physician's order for fluid restriction resulting in the risk for potential fluid excess. Findings include:</p> <p>Interview with licensed practical nurse (LPN) A on 7/7/14 at 4:30 p.m. regarding resident 1 revealed he had: *"Hydration issues." *A urinary catheter (tube that drains urine from the bladder). *A history of dehydration since his admission to the facility in 2013. *A history of urinary tract infections (UTI).</p> <p>Record review of resident 1 revealed: *He had a physician's order dated 9/13/13 for daily intake and output (measurement of both fluid intake and of urine output). *He had a history of recent diagnoses of dehydration and a UTI noted in the nursing notes</p>	F 327	<p>F327</p> <p>1. Intake & Output monitoring for Resident 1 has been D/C'd and care plan updated to reflect risk for dehydration. * on 8/11/14 KGS/DDH/MF</p> <p>Intakes are being documented for resident 2.</p> <p>Nurse G will be provided education regarding documentation of intake and output.</p> <p>2. All residents on MD ordered intake and/or output monitoring have the potential to be affected.</p> <p>3. Nursing and dietary staff will be provided education regarding monitoring intake and output per MD orders.</p> <p>4. DNS/Designee will audit Intake/Output records weekly x 4 weeks and monthly x 3 months. The results of these audits will be presented to the monthly QAPI Committee for review and recommendation. x by the Director Nursing Services/ Designee KGS/DDH/MF</p>	8/22/14

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F 327	Continued From page 15 dated 6/30/14. *He had output measurements noted every shift, three times per day. *He had not had any intake measurements documented. *The care plan had not addressed hydration. Surveyor 32335 2. Review of resident 2's current physician's orders revealed a 2500 cubic centimeters (cc) fluid restriction per day. Review of resident 2's medical record revealed no daily monitoring of her fluid intake. Surveyor 33488 Interview on 7/8/14 at 10:30 a.m. with registered nurse G regarding documentation of intake revealed the provider had not monitored or recorded intake on any resident in the facility. "This facility doesn't do that." Interview on 7/9/14 at 10:50 a.m. with the director of nursing regarding intake monitoring and care plan documentation revealed: *It had been her expectation the nursing staff had been recording intake. *She agreed the care plan for resident 1 needed to reflect his recent hydration issues. Review of the provider's 2006 Intake and Output policy revealed staff were to measure and record all liquids consumed for residents with a physician's order for measurement of intake and output or an order for fluid restriction.	F 327			
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333			

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F 333	<p>Continued From page 16</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, and policy review, the provider failed to follow the manufacturer's instructions for the use of an insulin flex pen (multiple use container prefilled with insulin for injection) for one of one randomly observed resident (17). Findings include:</p> <p>1. Observation on 7/8/14 at 10:45 a.m. revealed licensed practical nurse (LPN) A: *Secured the insulin flex pen for resident 17 and entered the resident's room. *Had not primed the flex pen as identified in the manufacturer's instructions. *Immediately removed the needle from the resident's arm after she had pressed the button on the end of the flex pen. *Had not held the needle in place with the button depressed for the six seconds identified as needed by the manufacturer for the insulin dose to be delivered.</p> <p>Interview on 7/8/14 at 10:48 a.m. with LPN A revealed she: *Had noticed the blood sugar levels of the residents who had physicians' orders for flex pens had not always lowered as would have been expected after an insulin injection. *Had no training in using an insulin flex pen.</p> <p>Interview on 7/9/14 at 1:30 p.m. with LPN I revealed: *Her description of how to use an insulin flex pen</p>	F 333	<p>F 333</p> <p>1. Resident 17 is receiving insulin via Flex Pen per manufacturers recommendation.</p> <p>LPN (A) was educated on proper flex pen usage 7/31/14.</p> <p>2. All residents receiving Insulin via Flex Pen have the potential to be affected.</p> <p>3. All licensed staff will be trained on the manufacturer's recommendations for administering Insulin via Flex Pen.</p> <p>4. DNS/Designee will randomly Audit Insulin administration via flex pen weekly x 4 weeks and monthly x 3 months to ensure manufacturer's recommendations are followed. The results of these audits will be presented to the monthly QAPI committee for review and recommendation.</p> <p><i>*by the Director Nursing Services/ Designee K6/SDDH/MF</i></p>	8/27/14

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F 333	Continued From page 17 did not include priming the syringe or depressing the button and holding the needle in place for six seconds to deliver the insulin. *She had no training on using an insulin flex pen. Interview on 7/9/14 at 2:05 p.m. with the director of nursing revealed she: *Expected the nurses to have learned how to use the insulin flex pens during their nurses training. *Had not provided any training for the nursing staff on the use of the flex pen. Review of provider's October 2007 Medication Administration - Subcutaneous Insulin policy revealed: *Directed nurse to: -Inject the insulin slowly. -Leave the needle in the skin for several seconds after injection with the finger on the plunger or per manufacturer's recommendations. *There was no mention as to how to use an insulin flex pen. Review of the undated manufacturer's instructions for use revealed: *An air shot (priming) of two units (measurement) should be completed before each injection. *Keep the needle in the skin for at least six seconds, and keep the push-button pressed all the way in until the needle has been pulled out from the skin. That would ensure the full dose had been given.	F 333			
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization,	F 334			

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F 334	<p>Continued From page 18</p> <p>each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p>	F 334	<p>F 334</p> <ol style="list-style-type: none"> 1. Resident 7 has been administered a pneumococcal vaccination. 2. All residents have the potential to be affected. 3. Licensed staff will be educated to offer all residents a pneumococcal immunization on admission to the facility. 4. DNS/Designee will audit new admissions for pneumococcal vaccinations weekly x 4 weeks and monthly x 3 months. The results of these audits will be presented to the monthly QAPI Committee for review and recommendation. <p><i>*by the Director Nursing Services/ Designee KJSDOH/ME</i></p>	8/29/14

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F 334	<p>Continued From page 19</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on record review, interview, and policy review, the provider failed to ensure 1 of 13 sampled residents (7) had received the pneumococcal vaccination (vaccine to prevent pneumonia) upon admission to the facility which could result in the risk for contracting pneumonia. Findings include:</p> <p>1. Review of resident 7's medical record revealed he had: *An admission date of 4/14/14. *No documentation in his record he had received a pneumococcal vaccination from the provider after he had been admitted to the facility.</p>	F 334			

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F 334	Continued From page 20	F 334		
F 371 SS=D	<p>Interview on 7/8/14 at 5:45 p.m. with the director of nursing revealed the resident had signed a consent form to receive the vaccine. However staff had not followed through with the administration of that vaccine.</p> <p>Review of the revised 2013 Influenza/ Pneumococcal Immunization Guideline policy revealed "If the resident's previous immunization history is unable to be obtained the request should be made that the resident receive the pneumococcal vaccine."</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to monitor: *Hot temperatures of pureed diets and cold food temperatures in the Alzheimer's care unit (ACU) during one of one meal observation. *Breakfast food temperatures in the main dining room for one of one meal service. Findings include:</p>	F 371	<p>F371</p> <p>1. Holding temperatures of all hot and cold food items are being taken and recorded per policy.</p> <p>CNA J was educated on taking and recording holding temperatures of food on 7/31/14.</p> <p>2. All residents have the potential to be affected.</p> <p>3. Dietary staff will be educated to take and record Holding temperatures of food in the kitchen prior to serving in the main dining room. ACU Staff will be educated to take and record Holding temperatures of food prior to serving in the ACU Dining Room.</p>	8/20/14

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F 371	Continued From page 21 1. Observation on 7/8/14 from 11:00 a.m. through 12:15 p.m. in the kitchen revealed: *The menu included country bean soup, turkey Cobb salad, and breadsticks. *They also served fruit and dessert during that meal. *No temperatures had been taken by staff in the kitchen before the cart had been taken to the ACU. *At 12:10 p.m. in the ACU certified nursing assistant (CNA) J had taken the temperature of the soup but not the items for the pureed diet or the turkey Cobb salad. *CNA J served the meal from the steam table after she had taken the temperature of the soup. Review of the ACU temperature logs from 4/22/14 through 7/8/14 revealed: *The wrong date had been written in for the 7/8/14 lunch observed. *A temperature for the soup had been recorded, but no other food temperatures for that lunch meal had been documented. *No temperatures for any pureed items during that period of time had been documented. Interview on 7/8/14 at 2:15 p.m. with the ACU coordinator and the dietary manager revealed they had not been taking temperatures of the cold foods in the ACU. Temperatures should have been taken for the cold food items and for the pureed diet foods. 2. Review of the March, May, and June 2014 main dining room food temperature logs revealed temperatures had not been taken for any of the breakfast food items.	F 371	4. DSM/ACU Director/Designee will audit meal service weekly x 4 weeks and monthly x 3 months to ensure holding temperatures of hot and cold foods are taken and recorded. The results of these audits will be presented to the monthly QAPI Committee for review and recommendation. <i>*by the DSM/ACU Director Designee K/S/00041111F</i>	

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F 371	Continued From page 22 Interview on 7/9/14 at 10:00 a.m. with the dietary manager revealed they should have been taking temperatures of the breakfast food items. 3. Review of the provider's 2011 Holding and Serving policy revealed: **Holding temperatures of all hot and cold items must be taken and recorded after full preparation and immediately before starting meal service." *Monitoring temperatures of mechanically altered foods (pureed and ground) should have occurred shortly before the start of the meal service.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	F441 A. 1. Facility whirlpool tub has been disinfected per manufacturers recommendations. CNA's C & D were educated on the proper procedure for cleaning the whirlpool tub on 7/31/14. Facility shower chairs have been disinfected per manufacturer's recommendations. Mechanical lift grab bar handles are being disinfected between resident use. CNA F was educated on the need to disinfect lift handles between resident use on 7/31/14.	8/22/14

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F 441	<p>Continued From page 23</p> <p>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: 33488 A. Based on observation, interview, manufacturer's guidelines, South Dakota Cosmetology guidelines, and policy review, the provider failed to: *Disinfect: -One of one whirlpool tub, -One of one shower chair, -Three of three resident lift grab bar handles between resident use or according to manufacturer's guidelines which resulted in the potential for cross-contamination. *Disinfect curlers between resident use in one of one beauty shop resulting in the potential for cross-contamination. *Failed to appropriately disinfect multiple use glucometers (machine that checks blood glucose) between resident use resulting in the potential for cross-contamination. Findings include:</p> <p>1. Observation, interview, and manufacturer's guideline review on 7/8/14 at 8:30 a.m. with</p>	F 441	<p>Curlers are being cleared of hair/debris between resident use according to guidance from Cosmetology commission of SD. Beautician was educated 7/31/14</p> <p>Individual glucometers were purchased; glucometers are no longer used for multiple residents.</p> <p>2. All residents have the potential to be affected.</p> <p>3. Nursing staff will be provided education on following manufacturer's recommendation for disinfecting Whirlpool tub and shower chairs.</p> <p>Nursing staff will be educated on disinfecting lift grab bar handles between resident use.</p> <p>Beautician will be provided education on disinfecting multi-use beauty shop items per guidelines.</p> <p>Licensed staff will be educated on disinfecting glucometers per manufacturer's recommendations.</p> <p>* 4. DNS/Designee will audit Whirlpool tub and shower chair cleaning weekly x 4 weeks and monthly x 3 months..</p> <p>DNS/Designee will audit Lift handle disinfection weekly x 4 weeks and monthly x 3 months.</p> <p><i>All new employees will receive these trainings in the "New Hire" orientation. KGS/DOH/MF</i></p>	

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F 441	<p>Continued From page 24</p> <p>certified nursing assistant (CNA) C in the bathing room revealed she:</p> <p>*Would spray the shower chair with Classic Whirlpool Disinfectant Cleaner and let it sit for thirty seconds before rinsing.</p> <p>*Would only lift the seat on the shower chair to clean underneath it if a resident was known to have soiled the seat.</p> <p>*Was unaware the above cleaner needed to sit ten minutes according to the manufacturer's guidelines for porous (having small holes) materials like the plastic shower chair.</p> <p>*Would spray the whirlpool tub with the self-dispensing disinfectant Cen-Kleen IV, turn the jets on, and then off right away, and would rinse the whirlpool tub.</p> <p>*Was unaware of the specific cleaning instructions required for the whirlpool tub by the manufacturer.</p> <p>*Stated two of the fifty seven residents received whirlpool baths, one of which had chronic methicillin resistant staphylococcus aureus (MRSA) [bacterial infection resistant to most antibiotics] infected sores to his abdomen, resident 17. The remaining residents took showers and used the shower chair for bathing.</p> <p>Observation, interview, and manufacturer's guideline review on 7/8/14 at 8:45 a.m. of CNA D regarding the shower chair and whirlpool cleaning revealed she:</p> <p>*Would spray the shower chair with Classic Whirlpool Disinfectant Cleaner and let it sit for five minutes before rinsing.</p> <p>*Was unaware the above cleaner needed to sit ten minutes according to manufacturer's guidelines for porous materials like the plastic shower chair.</p> <p>*Would spray the whirlpool tub with the</p>	F 441	<p>ED/Designee will audit curlers between use weekly x 4 weeks and monthly x 3 months to ensure they are free of hair/debris.</p> <p>DNS/Designee will audit Glucometer use weekly x 4 weeks and monthly x 3 months to ensure that they are not used for multiple residents.</p> <p>Results of these audits will be presented to the monthly QAPI committee for review and recommendation.</p> <p><i>*by the Executive Director/ Director Nursing Services/ Designee K6/SDDH/MF</i></p> <p>B.</p> <p>1. Nebulizers were cleaned for residents 9 & 22 on 7/10/14.</p> <p>2. All residents who receive Nebulizer treatments have the potential to be affected. *All nebulizers for those residents are cleaned between each use. K6/SDDH/MF</p> <p>3. Licensed staff will be educated on system for cleaning nebulizers and accessories.</p> <p>4. DNS/Designee will audit nebulizer and accessory cleaning weekly x 4 weeks and monthly x 3 months. The results of these audits will be presented to the monthly QAPI Committee for review and recommendation.</p> <p><i>*by the Director Nursing Services/ Designee K6/SDDH/MF</i></p>	

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F 441	<p>Continued From page 25</p> <p>self-dispensing disinfectant Cen-Kleen IV, turn the jets on, then let it set for a few minutes, and then would rinse the whirlpool tub.</p> <p>*Was unaware of the specific cleaning instructions required for the whirlpool tub by the manufacturer.</p> <p>Review of both of the manufacture's guidelines for the Parker whirlpool tub and Cen-Kleen IV disinfectant revealed the disinfectant should remain in the whirlpool tub for approximately ten minutes while continuing to be scrubbed.</p> <p>Review of the undated manufacturer's guidelines for Classic Whirlpool Disinfectant Cleaner, Answers to Frequently Asked Questions About Whirlpool Tub Cleaning & Disinfection, <http://www.centraolutions.com/whirlpool.html>, accessed on 7/14/14, revealed a contact time of ten minutes was required for disinfection.</p> <p>2. Random observations on 7/9/14 from 9:45 a.m. to 10:15 a.m. of CNA F while she used a mechanical lift for residents 2, 12, and 16 revealed:</p> <p>*The residents would grab the support grips with their hands while being transferred to the toilet.</p> <p>*CNA F had not sanitized or cleaned the support grips between resident's use.</p> <p>*She was unaware they needed to be cleaned and disinfected between resident use.</p> <p>Review of the August 2013 manufacture's guidelines for the mechanical lift revealed it "is recommended that equipment is regularly cleaned between each resident use, if necessary, and daily as a minimum."</p> <p>3. Observation and interview on 7/8/14 at 9:10</p>	F 441	<p>C.</p> <p>1. Appropriate hand-washing technique and glove use are being used while providing personal care.</p> <p>CNAs B & F were educated on proper handwashing on 7/31/14.</p> <p>2. All residents have the potential to be affected.</p> <p>3. Nursing staff will be provided education regarding proper hand washing technique and glove use.</p> <p>4. DNS/Designee will audit hand washing and glove use weekly x 4 weeks and monthly x 3 months. The results of these audits will be presented to the monthly QAPI Committee for review and recommendation.</p> <p><i>*by the Director Nursing Services/ Designee KKH/DHMF</i></p>	

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F 441	<p>Continued From page 26</p> <p>a.m. with licensed beautician E in the beauty shop revealed:</p> <ul style="list-style-type: none"> *Multiple-use hair curlers were found to have large amounts of hair and debris in them. *She provided the hair curlers for resident use. *She would take the hair curlers home "about once a month" and clean them with Barbicide (a chemical used to disinfect multiple-use beauty shop items). *She was unaware the South Dakota Cosmetology infection control guidelines required disinfection of multiple use items between each resident's use. *She agreed the potential for cross-contamination existed, and she should have cleaned them between each resident's use. **"Approximately twenty" unidentified residents of the fifty-seven total at the facility received services by the beautician. <p>Review of the South Dakota Cosmetology Commission guidelines, Consumer Information, Safe and Sanitary Conditions, <http://dlr.sd.gov/bdcomm/cosmet/ccconsumerinfo.aspx> accessed on 7/14/14, revealed multiple use items were to be disinfected between each use.</p> <p>4. Interview on 7/8/14 at 2:40 p.m. with the director of nursing (DON) regarding the above disinfection of the whirlpool tub, shower chair, grab bars on the mechanical lifts, and hair curlers revealed:</p> <ul style="list-style-type: none"> *It was her expectation manufacturer's guidelines would be followed to clean the whirlpool tub and shower chair. *It was her expectation the beautician was to have disinfected multiple-use items such as hair curlers between use. 	F 441			

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F 441	<p>Continued From page 27</p> <p>*She agreed the above items were an area of concern as they had all been cross-contaminated between resident use. The potential for the spread of possible infection was high.</p> <p>Surveyor: 33265</p> <p>5. Observation and interview on 7/8/14 from 10:40 a.m. through 11:25 a.m. of licensed practical nurses (LPN) A and H revealed:</p> <p>*Both LPNs wiped the glucometers off with a 70 % alcohol wipe after use.</p> <p>*Both LPNs stated alcohol wipes were the usual method of cleaning the glucometers after use.</p> <p>*No further cleaning or decontamination of the glucometers was done before the next use.</p> <p>Interview on 7/8/14 at 5:00 p.m. with the DON revealed:</p> <p>*They shared glucometers between residents and had one glucometer on each of the three medication carts.</p> <p>*She was aware the nurses were using alcohol wipes to clean the glucometers after use.</p> <p>*She was not sure what the manufacturer's recommendations were for cleaning of the glucometers, but she would find and provide the manufacturer's instructions.</p> <p>Review of the provided glucometer manufacturer's instructions revealed a 70% alcohol solution was an acceptable cleaning solution. However the provider's policy identified a different cleaning and decontamination procedure.</p> <p>Review of the provider's August 2012 Blood Glucose Monitor Decontamination policy revealed:</p> <p>*Blood glucose monitors would be cleaned and</p>	F 441			

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F 441	<p>Continued From page 28</p> <p>decontaminated with wipes after use on each resident.</p> <p>*The wipes used for decontamination were to have been able to kill multiple diseases and bacteria.</p> <p>-The 70 % alcohol solution would not kill the multiple diseases and bacteria listed.</p> <p>*If wipes meeting specifications were not available the instructions were to use a one to ten bleach solution.</p> <p>Further interview on 7/9/14 at 2:05 p.m. with the DON revealed she agreed a cleaning and decontaminating agent other than 70% alcohol needed to be utilized on the blood glucose monitors.</p> <p>B. Based on observation, interview, record review, and policy review, the provider failed to have a system for cleaning the nebulizer machine (used to turn liquid medication into a mist to be inhaled) and accessories for two of two observed residents (9 and 22). Findings include:</p> <p>1. Observation on 7/8/14 from 10:35 a.m. through 11:50 a.m. of two residents' nebulizer medication administrations revealed:</p> <p>*For resident 22 licensed practical nurse (LPN) A:</p> <p>-Entered the resident's room at 10:35 a.m. with the nebulizer medication.</p> <p>-Found the nebulizer mask to be intact.</p> <p>-Opened the nebulizer well and placed liquid medication in the well.</p> <p>-Started the nebulizer machine at 10:37 a.m.</p> <p>*At 10:50 a.m. the nebulizer mask had been removed from resident 18's face and was placed intact on the bedside stand.</p> <p>*At 11:00 a.m. and at 11:30 a.m. resident 18's nebulizer mask was in the same state and</p>	F 441		

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F 441	<p>Continued From page 29 condition as seen at 10:50 a.m. *For resident 9 LPN H: -Entered resident 9's room at 11:22 a.m. with the nebulizer medication. -Found nebulizer mask to be intact but containing fluid. -Took nebulizer apart and tapped out the fluid onto a Kleenex. -Wiped inside of the nebulizer well with a dry Kleenex. -Placed the liquid medication in the nebulizer well. -Closed the well container. -Placed the mask on resident 9 and started the nebulizer machine at 11:25 a.m. *At 11:40 a.m. the nebulizer mask had been removed from resident 9's face and was placed intact on the bedside stand. *At 11:45 a.m. and at 1:10 p.m. resident 9's nebulizer mask was in the same state and condition as was seen at 11:40 a.m. *Neither of the above residents' nebulizer, mask, or well had been taken apart, cleaned, and left to air dry.</p> <p>Interview on 7/8/14 at 5:00 p.m. with the director of nursing (DON) revealed she was not: *Aware the nebulizer mask or mouthpiece, and accessory pieces were not being cleaned after each use. *Sure what the manufacturer's instructions suggested for cleaning.</p> <p>Review of the provider's 2013 Phillips Respironics Innospire Essence nebulizer system manufacturer's instructions revealed suggested cleaning was: *Use of a damp cloth to wipe down the outside of the compressor at least once every month. *Refer to nebulizer accessory instructions for how</p>	F 441			

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F 441	<p>Continued From page 30 to clean nebulizer accessories.</p> <p>Review of the undated instructions in the two Medline nebulizer accessory kits utilized by the provider revealed no cleaning instructions were included.</p> <p>Further interview on 7/9/14 at 2:05 p.m. with the DON revealed she: *Was not aware the nebulizer accessory kits were not intended for reprocessing. *Had no manufacturer's instructions on how to clean the nebulizer mask, mouthpiece, and accessory pieces. *Had no policy identifying a plan for replacing nebulizer mask, mouthpiece, and accessories on a routine basis.</p> <p>Review of the provider's October 2007 Nebulizer policy revealed the nebulizers were to be cleaned according to the manufacturer's instructions.</p> <p>Review of Ofelia Tablan et al., Guidelines for Preventing Health-Care-Associated Pneumonia, 2003, p. 59, revealed for small-volume nebulizers, in-line and hand held, the nebulizer should be cleaned, disinfected, rinsed with sterile water, and dried between treatments on the same patient.</p> <p>Surveyor: 32355 Surveyor 33488 C. Based on observation, interview, and policy review, the provider failed to use appropriate hand-washing technique while providing personal care for three of three residents (5, 12, and 16)</p>	F 441		

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F 441	<p>Continued From page 31</p> <p>resulting in the potential for cross-contamination. Findings include:</p> <p>Surveyor 32355</p> <p>1. Observation on 7/9/14 from 8:50 a.m. through 9:25 a.m. of CNA B during personal cares for resident 5 revealed:</p> <ul style="list-style-type: none"> *The resident had been resting in her bed. *CNA B had gathered all of the necessary supplies to provide personal care for the resident. *She retrieved a pair of gloves and put them on. With those gloves on she had: <ul style="list-style-type: none"> -Cleansed the resident's catheter tubing (tube inserted into the bladder) with alcohol wipes. -Retrieved a wet wash cloth and cleansed the resident's perineal area (area located between the thighs). -Reached inside of the garbage and retrieved a roll of garbage can liners. She tore one off the roll, opened it up, and placed it on the resident's mattress. -Placed the soiled wash clothes inside the garbage bag. -Partially put on the resident's underwear and slacks and assisted her to sit on the edge of the bed. *She removed those gloves and left the room to retrieve the stand-aide (device to assist with transfers) from the hallway. She had not washed or sanitized her hands prior to leaving the room. *She retrieved another pair of gloves and put them on. With those gloves on she had: <ul style="list-style-type: none"> -Assisted the resident with the placement of her hands on the stand-aide, grabbed the hand control device for the stand-aide, and stood the resident up. -Checked her bottom, pulled up her underwear and slacks, and retrieved her wheelchair. -Returned to the front of the stand-aide, retrieved 	F 441		
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F 441	<p>Continued From page 32</p> <p>the hand control device, and placed the resident in her wheelchair.</p> <p>*She removed those gloves and pushed the resident into the bathroom and set her up to wash her face, hands, and brush her teeth. She had not washed or sanitized her hands prior to assisting the resident.</p> <p>*She retrieved another pair of gloves and put them on. With those gloves on she had:</p> <ul style="list-style-type: none"> -Opened the toothbrush container, retrieved the toothbrush, and handed it to the resident. -Replaced the toothbrush in the container after the resident had finished brushing her teeth. -Placed her hands on the handles of the wheelchair and pushed the resident to the dining room. <p>*She removed her gloves and went into the kitchen and retrieved food for the resident.</p> <p>*She assisted the resident with the setup of her food.</p> <p>*She then washed and sanitized her hands. That had been the only time she had washed or sanitized her hands during the entire above process.</p> <p>Interview on 7/9/14 at 9:30 a.m. with CNA B confirmed she had not properly removed her gloves and sanitized her hands when working from dirty to clean. She agreed there had been potential for cross-contamination to other residents.</p> <p>Interview on 7/9/14 at 10:45 a.m. with the DON revealed:</p> <p>*She would have expected CNA B to have removed her gloves and performed hand hygiene when working from clean to dirty.</p> <p>*There had been potential for cross-contamination due to the unsanitary</p>	F 441		

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F 441	<p>Continued From page 33 procedure that was used.</p> <p>Review of the provider's 2006 Catheter Care, Indwelling Catheter policy revealed: *The purpose was to prevent infections. *Gloves were to have been removed after cleansing of the catheter. *No documentation to support when washing or sanitizing of the hands should occur.</p> <p>Review of the provider's 2006 Perineal Care policy revealed: *Purpose was to prevent infections and odor. *Gloves were to have been worn during perineal care and removed when they had come in contact with bowel movement. *Gloves were to have been removed after perineal care. *No documentation to support when washing or sanitizing of the hands should have occurred.</p> <p>Review of the provider's 2006 Handwashing policy revealed: *Purpose: -"Medical asepsis (method of keeping clean) to control infection." -"To reduce transmission of organisms (a living cell) from resident to resident." -"To reduce transmission of organisms from nursing staff to resident." -"To reduce transmission of organisms from resident to nursing staff." *General instructions: -"Wash hands before and after resident contact." -"Wash hands when soiled."</p> <p>2. Random observation on 7/9/14 at 9:45 a.m. of CNA F providing personal care to resident 12 in his bathroom revealed she:</p>	F 441		

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F 441	<p>Continued From page 34</p> <ul style="list-style-type: none"> *Placed resident 12 in the mechanical lift and transported him to his bathroom. *Proceeded to pull down his pants and undergarment with her bare hands. *Set the resident on the toilet using the controls on the lift. *Walked out of the resident's room, proceeded down the hallway to the public bathroom, and washed her hands. *She put gloves on and wiped the residents buttocks with a wet washcloth that she moistened in the residents sink (located in his bathroom). *After she finished wiping him she proceeded to pull up his undergarment and pants with her contaminated gloves. *Transported the resident to his bed and laid him down. *Removed her contaminated gloves and proceeded back down the hallway to wash her hands. *Touched the back of his shirt of an unidentified resident on her way to the public restroom with her unwashed hand. <p>Random observation on 7/9/14 at 10:10 a.m. of CNA F providing personal care to resident 16 in his bathroom revealed she:</p> <ul style="list-style-type: none"> *Placed resident 16 in the mechanical lift and transport her to her bathroom. *Proceeded to pull down her pants and undergarment with her bare hands. *Set the resident on the toilet using the controls on the lift. *Walked out of the resident's room, proceeded down the hallway to the public bathroom, and washed her hands. <p>Interview on 7/9/14 at 10:20 a.m. with CNA F regarding the above personal cares revealed she</p>	F 441		

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

PRINTED: 07/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MADISON			STREET ADDRESS, CITY, STATE, ZIP CODE 718 NE 8TH ST MADISON, SD 57042	
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F 441	Continued From page 35 agreed she should have: *Used gloves to remove the above resident's pants and undergarments. *Washed her hands in the residents bathroom sink after cares. *Discarded contaminated gloves between tasks. Interview with the nursing assistant trainer, registered nurse (RN) G at 10:20 a.m. revealed it was her expectation that CNA's would have used appropriate hand-washing technique as they had been trained on when providing resident care.	F 441		

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

ORIGINAL

PRINTED: 07/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MADISON	STREET ADDRESS, CITY, STATE, ZIP CODE 718 NE 8TH ST MADISON, SD 57042
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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/9/14. Golden LivingCenter-Madison was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 7/9/14 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 020 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and document review, the provider failed to maintain the 60 minute fire resistive rating of one randomly observed dumbwaiter door assembly at the main level B wing service area. Findings include:	K 020		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kathleen Thomas</i>	TITLE Executive Director	(X6) DATE 8/6/14
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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 required to continued program participation.

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K 020	Continued From page 1 1. Observation at 11:00 a.m. on 7/9/14 revealed the corridor door to the dumbwaiter on the main level B wing service area did not have a label to identify the fire resistive rating. Review of the previous life safety code data indicated that condition had existed since the original construction.	K 020		
K 033 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain a one hour fire resistive path of egress from the basement to the exterior of the building. One of two basement stairways (north stairway) discharged into the main level corridor system. Findings include:</p> <p>1. Observation at 1:00 p.m. on 7/9/14 revealed the north stairway from the basement discharged into the main level corridor system. A continuous</p>	K 033		F

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K 033	<p>Continued From page 2</p> <p>one hour fire resistive path of egress was not provided to the exterior of the building. Review of previous life safety code survey data indicated that condition had existed since the original construction.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of deficiencies identified in K000.</p>	K 033		

ORIGINAL

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10645	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MADISON	STREET ADDRESS, CITY, STATE, ZIP CODE 718 NE 8TH STREET MADISON, SD 57042
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S 000	Initial Comments Surveyor: 32335 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/7/14 through 7/9/14. Golden LivingCenter - Madison was found not in compliance with the following requirement(s): S166, S206, and S301.	S 000	Addendums noted with an asterisk per 8/6/14 telephone to facility administrator. KG/SBDOH/MF	
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 when the door is closed;	S 166	<p>S 166</p> <p>1. All doors identified [redacted] <i>*are alarmed 24 hours per day. KG/SBDOH/MF</i></p> <p>All Residents have the potential to be affected.</p> <p>2. All doors [redacted] <i>*are alarmed 24 hours per day. KG/SBDOH/MF</i></p> <p>3. ED/Designee will audit door alarm weekly x 4 weeks and monthly x 3 months. The results of these audits will be presented to the monthly QAPI committee for review and recommendation. <i>*by the Executive Director/Designee KG/SBDOH/MF</i></p>	8/6/14

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

Mattie Thomas

TITLE

Executive Director

(X6) DATE

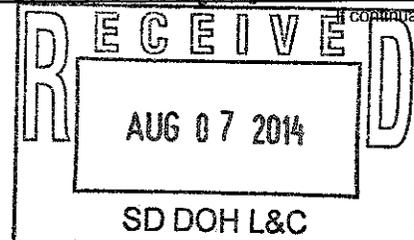
8/6/14

STATE FORM

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VIT411

If continuation sheet 1 of 8



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10645	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2014
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S 166	<p>Continued From page 1</p> <p>(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: 33488 Based on observation, interview, record review, and policy review, the provider failed to alarm two of nine entrance/exit doors (main/south entrance and the east exit door across from the director of nursing's office) resulting in the potential for resident elopement and injury. Findings include:</p> <p>1. Random observations on 7/7/14 and 7/8/14 from 8:00 a.m. through 6:00 p.m. revealed: *The main/south entrance door was not monitored and unalarmed from "approximately 4:30 or 5:00 p.m. to 8:00 p.m." per the maintenance supervisor until it automatically alarmed at 6:00 p.m. each evening Monday through Friday. *It was unalarmed and not monitored on weekends. *The east exit door was not monitored and was found to be unalarmed from 6:00 a.m. through 6:00 p.m. daily. That door was commonly used by residents and visitors to access the smoking area</p>	S 166		

South Dakota Department of Health

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S 166	<p>Continued From page 2</p> <p>or exit the building to a parking lot.</p> <p>Interview and walk-through on 07/08/14 at 3:00 p.m. of the facility with the maintenance supervisor revealed:</p> <ul style="list-style-type: none"> *The above mentioned doors were not alarmed during the day. *The main entrance was only monitored when the unidentified front door greeter had been working at her desk. He stated he thought her usual scheduled hours were weekdays 8:00 a.m. until 4:00 to 4:30 p.m. *The east door was not monitored. *He was unaware of the state rule regarding door alarms. *He thought the WanderGuard system was sufficient for residents known to be at risk for elopements. <p>Interview on 7/8/14 at 3:15 p.m. with the director of nursing and the administrator regarding the door alarms revealed:</p> <ul style="list-style-type: none"> *The above doors were not actively alarmed during the day. *They believed the doors were set to alarm from 8:00 a.m. to 6:00 p.m. during the winter months and 6:00 a.m. to 8:00 p.m. during the spring, summer, and fall (in accordance with daylight hours). *They agreed that was a potential elopement and safety risk for residents. *They agreed they had previous elopements from the facility. <p>2. Review of the provider's incident report dated 9/28/13 involving resident 2 revealed:</p> <ul style="list-style-type: none"> *The resident had reported to staff at 5:00 p.m. that she had "not been to Sioux Falls in a while and she was going to run away." *The resident was noticed in the parking lot 	S 166		

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S 166	Continued From page 3 outside at 6:00 p.m by staff and brought back to the facility. Review of the provider's undated Facility Security Access Control Entrance and Exit Log revealed: *The main entrance door was to be alarmed from 6:00 a.m. through 6:00 p.m. *The east door was to be alarmed "24/7 [twenty-four hours, seven days per week]." Review of the provider's undated Facility Security Access Control Personal Protection Procedures policy revealed no policy regarding residents not identified to be at risk for elopement.	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 reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks , and hydration needs of...residents.	S 206	<p>S 206</p> <p>1. Dietary aides K and M and nurse aide L have been provided training in "taking care of residents with special or unique needs" and "Dining assistance, nutritional risks, and hydration needs of residents."</p> <p>All staff have the potential to be affected.</p> <p>2. All newly hired staff will be provided the required trainings as identified in 44:04:04:05 as a part of their orientation program. Department managers will be educated on this requirement.</p> <p>3. ED/Designee will audit new hire education records weekly x 4 weeks and monthly x 3 months. The results of these audits will be presented to the monthly QAPI Committee for review and recommendation.</p> <p><i>by the Executive Director/Designee</i> <i>KE/SDCH/MF</i></p>	8/22/14

South Dakota Department of Health

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S 206	<p>Continued From page 4</p> <p>...Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32355 Based on record review and interview, the provider failed to ensure three of six newly hired employees (K, L, and M) received all ten of the orientation programs. Findings include:</p> <p>1. Review of dietary aides K and M and nurse aide L's training and orientation records revealed they had not received training for: *Taking care of residents with special or unique needs. *Dining assistance, nutritional risks, and hydration needs of residents.</p> <p>Interview on 7/9/14 at 11:30 a.m. with the administrator revealed: *She had not been aware the above newly hired employees had not received all of the required training during their orientation. *She had been unable to find any further education to support the two above mentioned areas had been addressed during their orientation and training program.</p> <p>The provider had been unable to provide a policy to support the orientation and training requirements for newly hired employees.</p>	S 206		
S 301	44:04:07:16 Required dietary inervice training	S 301		

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S 301	<p>Continued From page 5</p> <p>The dietary manager or the dietitian in ...nursing facilities...shall provide ongoing inservice training for all dietary and food-handling employees...Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32355</p> <p>Surveyor: 32335 Based on observation, record review, and interview, the provider failed to supply the required dietary in-services to all staff in the Alzheimer's care unit (ACU) including the ACU coordinator and one randomly observed certified nursing assistant (J) who handled and served food at meal times. Findings include:</p> <p>Surveyor: 32355 1. Observation on 7/8/14 at 11:30 a.m. of the ACU coordinator revealed: *She had returned from retrieving several slices of cheese from the main kitchen. Those cheese slices had been covered with plastic wrap. *She placed the cheese slices on the counter in the dining/activity area of the ACU. *She washed her hands and put on a pair of gloves. With those gloves she had: -Retrieved a small can of soup and a bowl. -Opened the can of soup and poured the contents into the bowl. -Opened the microwave, put the bowl of soup</p>	S 301	<p>S 301</p> <p>1. The required dietary in-services have been provided to the ACU Coordinator and Certified nursing assistant J.</p> <p>Residents of the Alzheimer's care unit have the potential to be affected.</p> <p>2. All staff working the Alzheimer's care unit will be provided the required dietary in-services.</p> <p>3. ED/Designee will audit food service in the ACU weekly x 4 weeks and monthly x 3 months.</p> <p>ED/Designee will audit Alzheimer's care unit staff education records weekly x 4 weeks and monthly x 3 months.</p> <p>The results of these audits will be presented to the monthly QAPI Committee for review and recommendation.</p> <p><i>* by the Executive Director/Designee KG/SDD/HMF</i></p>	8/22/14

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S 301	<p>Continued From page 6</p> <p>inside, and pushed several buttons to start the microwave.</p> <ul style="list-style-type: none"> -Opened the plastic covering on the cheese slices and a bag of bread. -Retrieved a plate and two slices of bread. -Placed the bread on top of the plate. -Opened a container of butter and picked up a knife that had been laying on the counter. -Held the container while she scooped up some butter onto the knife. -Held the bread slices with her left hand and spread the butter on top of the bread. -Retrieved a slice of cheese and placed it on top of one of the bread slices, laid the other slice of bread on top of the cheese, and cut the sandwich with the knife. -Opened the microwave and retrieved the bowl of soup. -Opened a package of crackers and laid them on the plate. -Placed the plate and the soup bowl in front of an unidentified resident. -Crushed the crackers and placed them in the soup. <p>*She washed her hands and put on a clean pair of gloves. With those gloves she had repeated the same process as above.</p> <p>The ACU coordinator had not completed one task at a time. She had not ensured her gloves remained clean or had changed gloves between each task. This had created the potential for cross-contamination while preparing ready to eat foods.</p> <p>Surveyor: 32335 2. Observation on 7/8/14 at 12:10 p.m. of certified nursing assistant J in the ACU revealed she had taken the temperature of the soup. She had not taken the temperatures of the food items for the</p>	S 301		

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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 301	<p>Continued From page 7</p> <p>pureed diet or the turkey Cobb salad.</p> <p>Review of the ACU temperature logs from 4/22/14 through 7/8/14 revealed: *The wrong date had been written in for the 7/8/14 lunch being observed. *A temperature for the soup and no other temperatures for that lunch meal. *No temperatures had been documented for any pureed items during that period of time.</p> <p>Interview on 7/8/14 at 2:15 p.m. with the ACU coordinator and the dietary manager revealed the staff working in the ACU had not received any of the required dietary in-services. Those in-services would have included food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.</p>	S 301		