

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

ORIGINAL

PRINTED: 07/14/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/05/2014</b>
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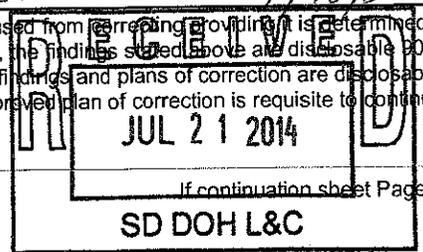
NAME OF PROVIDER OR SUPPLIER  <b>TIESZEN MEMORIAL HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>312 EAST STATE ST MARION, SD 57043</b>
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F 000	INITIAL COMMENTS  Surveyor: 32332 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/3/14 through 6/5/14. Tieszen Memorial Home was found not in compliance with the following requirement(s): F221, F280, F281, F323, F431, F441, and F514.	F 000	<i>Addendums noted with an asterisk per 7/18/14 telephone to facility administrator. @SDDOH/MF</i>	
F 221 SS=E	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: 32355 Based on observation, interview, record review, and policy review, the provider failed to appropriately assess and document the use of *A table top attached to a wheelchair for 1 of 1 sampled resident (1). *Side rails for 9 of 13 sampled residents (1, 2, 3, 4, 7, 8, 10, 11, and 12). Findings include:  1. Review of resident 1's 1/3/14 care plan revealed: *A focus area indicating he had been at risk for falls. *An intervention for a half wheelchair tray attached to his wheelchair. *The half wheelchair tray was to have been on the wheelchair when he had been sitting in it.	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Diana Wilson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/18/2014</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 221	<p>Continued From page 1</p> <p>*The half wheelchair tray was to have helped prevent him from falling out of his wheelchair.</p> <p>Review of resident 1's interdisciplinary post-fall assessment forms from 12/13/13 through 4/11/14 revealed:</p> <p>*He had a history of multiple falls out of his bed or wheelchair. Several of those falls had resulted in injuries to his head.</p> <p>*On 12/28/13 the director of nursing (DON) had referred him to therapy for the use of a half wheelchair tray.</p> <p>*All of the documentation from his falls after 12/28/13 revealed he was to have been using a half wheelchair tray.</p> <p>No other assessments or documentation had been located in his medical record to support the use of the half wheelchair tray.</p> <p>Observation on 6/3/14 at 12:10 p.m. of resident 1 revealed:</p> <p>*He had been in the dining room eating dinner.</p> <p>*He had been sitting in his wheelchair.</p> <p>*There had been no half wheelchair tray attached to his wheelchair.</p> <p>Interview on 6/3/14 at 1:50 p.m. with licensed practical nurse (LPN) K regarding resident 1 revealed:</p> <p>*He had a history of multiple falls with injury.</p> <p>*He would have attempted to transfer himself out of his wheelchair and bed.</p> <p>*He had a diagnosis of dementia with no safety awareness.</p> <p>*The half wheelchair tray had not been used for a long time. He had been able to remove the half wheelchair tray and continued to fall.</p>	F 221	<p>1. Resident #1 has been discharged from this facility. All residents are reviewed at the weekly interdisciplinary "At Risk" meeting. The Director of Nursing or designee will log all residents who are at a high risk for falling and present that information at the "At Risk" meeting. Those residents identified as high risk will have a physician's order obtained by the licensed nurse for Physical Therapy and/or Occupational Therapy to evaluate and treat to determine if wheelchair safety/positioning devices are needed and/or appropriate to assist in the prevention of falls. This will ensure appropriate documentation is completed and follow through by all disciplines and assist in the effectiveness of said interventions. The Director of Nursing or designee will keep a log of residents falls, dates of when physician's orders are obtained and therapy interventions are made, review of the action taken, and outcomes. The logs will be presented to the QAPI Committee for their review and further recommendations.</p> <p>2. Resident #1 has been discharged from this facility.</p> <p>3. Resident #7 will have a half side rail assessment completed by the MDS nurse. If half side rails are deemed appropriate, a physician's order will be obtained by the licensed nurse and the care plan will be updated by the licensed nurse to reflect the correct information. If Resident #7 continues to use a half side rail, the resident will be evaluated at the next quarterly assessment by the MDS nurse.</p>	

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F 221	<p>Continued From page 2</p> <p>Observation on 6/3/14 at 5:15 p.m. of resident 1 revealed he had been in the hallway sitting in his wheelchair. The half wheelchair tray had been in place.</p> <p>Interview on 6/3/14 at 5:20 p.m. with certified nursing assistant (CNA) D revealed resident 1 had not consistently utilized the half tray to his wheelchair. He had a history of removing the tray and hiding it from the staff.</p> <p>Interview on 6/3/14 at 5:30 p.m. with the Minimum Data Set (MDS) coordinator regarding resident 1 revealed: *She had not been aware he should still be using the the half wheelchair tray. *She had not been involved with the assessment and use of the half wheelchair tray. *The DON had referred him to the therapy staff for the use of the half wheelchair tray. *She had been unable to locate any further documentation in his chart to support the use of the half wheelchair tray.</p> <p>Interview on 6/4/14 at 9:30 a.m. with the MDS coordinator, physical therapist (PT) L, and certified occupational therapy (OT) assistant M regarding resident 1 revealed: *In December they had received an e-mail from the DON requesting them to attach a half wheelchair tray to his wheelchair. *They had not assessed or documented on the use of the half wheelchair tray for falls. *They had confirmed there should have been an assessment, documentation, and follow-up for appropriate use of the half wheelchair tray.</p> <p>2. Random observations from 6/3/14 through 6/4/14 of resident 1's bed revealed two side rails</p>	F 221	<p>4. Residents #2,3,4,8,10,11 and 12 will have a half side rail assessment completed by the MDS nurse. If the assessment indicates half side rails are appropriate, they will stay in place and documented as such by the licensed nurse. If the half side rails are no longer appropriate, the licensed nurse will notify the maintenance department to have the half side rail removed.</p> <p>The DON or designee will maintain a list of residents 2,3,4,8,10,11, and 12 and any other residents who are using 1/2 side rails on a log to monitor the assessment process completion dates, and the appropriateness and usage of the 1/2 side rails weekly x 4 weeks. The DON will present the data to the QAPI committee at their monthly meeting for their review and further recommendations to ensure the policy on 1/2 side rails is being followed.</p> <p>The Director of Nursing updated the "Half Side Rail Assessments" Policy on June 13, 2014 to include the appropriate timeframes in which 1/2 side rail assessments are to be completed. The DON will re-educate the nursing department staff on the use of 1/2 side rails on June 26, 2014, with a face to face inhouse inservice. The QAPI committee's next meeting is scheduled for July 16, 2014 and then again on August 18, 2014.</p> <p>The facility does not have a full side rail on any resident bed in the facility.</p>	7/25/2014	

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F 221	<p>Continued From page 3 up on the top half of his bed.</p> <p>Review of resident 1's medical record revealed: *He had a physician's order for the use of the side rail. *The side rail was to have been used for bed mobility. *He had required assistance with bed mobility and transfers from the staff. *No side rail assessment form had been found in his chart to support the use of the side rails.</p> <p>Interview on 6/3/14 at 3:00 p.m. with the MDS coordinator revealed: *She had not been aware a side rail assessment form should have been completed. *She had never completed a restraint assessment form to validate the use of resident 1's side rails for mobility. *She confirmed a restraint assessment form should be completed on all residents utilizing side rails.</p> <p>Surveyor: 32332 3. Random observations from 6/3/14 through 6/4/14 of resident 7's bed revealed one side rail in the up position and one side rail in the down position on the top half of her bed.</p> <p>Interview on 6/3/14 at 4:30 p.m. with resident 7 revealed she had used both side rails at night to assist with repositioning in bed.</p> <p>Review of resident 7's medical record revealed: *No physician's order for the use of side rails. *She had required limited assistance of one staff for bed mobility. *The 5/14/14 care plan had not included the use of side rails.</p>	F 221		

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F 221	<p>Continued From page 4</p> <p>*No side rail assessment form had been located in her chart to support the use of the side rails.</p> <p>Interview on 6/4/14 at 4:50 p.m. with the MDS coordinator revealed: *Resident 7 used the side rails to assist her with repositioning in bed. *She had not done an assessment for the use of her side rails. *She would have expected the side rails to have been on the care plan.</p> <p>Surveyor: 32331 4. Interview on 6/3/14 at 4:40 p.m. with the MDS coordinator regarding side rails on residents 2, 3, 4, 8, 10, 11, and 12's beds revealed: *Side rails were not being assessed. *No assessments were being done on any side rails. *She was not aware all side rails needed to have been assessed.</p> <p>Review of the provider's 8/16/07 Restraint Assessment policy revealed: *Before having used any physical restraints such as full side rails, full lap trays, etc. (and other things), a Pre-Restraining Assessment would have been completed. *A physician's order would have been obtained. *OT and physical therapy (PT) would have notified the director of nursing if treatment and recommendations included any restraints. *OT and PT would have documented in their notes why the recommendations were indicated. *If a resident had a restraint ordered it would have been re-evaluated at each care conference. *The policy had no definition of what was considered a restraint.</p>	F 221		

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F 280 SS=D	<p><b>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</b></p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, and care plan review, the provider failed to update, revise, and individualize care plans for 2 of 13 sampled residents (2 and 11). Findings include:</p> <p>1. Random observation and interviews on 6/3/14 and 6/5/14 at various times between 8:00 a.m. and 6:00 p.m. of resident 2 in his room revealed: *He had a history of: -Diabetes. -Stroke. -Amputations to his lower extremities.</p>	F 280	<p>1. Resident #2's care plan will be reviewed by the care plan team and appropriate revisions will be completed to reflect the resident's current care and condition. Specifically his half side rails will be assessed, the place the residents has his meals, and the resident's wishes in regards to socialization off the unit. The DON and the interdisciplinary team will meet, discuss, and update the facility's care plan policy on June 27, 2014.</p> <p>2. Resident #11 will have a smoking assessment completed by the MDS nurse to determine his safety in regards to smoking. Smoking assessments will be done quarterly with resident #11's assessment. Resident #11's care plan will be updated by the licensed nurse to reflect the data obtained from the smoking assessment completed.</p> <p>The DON and MDS coordinator reviewed the care plan policy on June 27, 2014. The DON will audit resident #2 and 11's care plans in addition to 10% of the facility census on a weekly basis for 4 weeks to monitor for updating. The DON will present the logs to the monthly QAPI committee for their review and further recommendations. The QAPI committee will meet on July 16, 2014 and August 18, 2014.</p> <p>The care plans do not auto fill upon admission to the facility. A basic care plan is prepared by the admitting licensed nurse upon admission based on the needs of the resident during the admission process. The care plans are updated by the licensed nurse and the care plan team as</p>	<p>7/17/14</p> <p>7/17/14</p>

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F 280	<p>Continued From page 6</p> <ul style="list-style-type: none"> <li>-An enlarged heart.</li> <li>-High blood pressure.</li> <li>-A feeding tube.</li> <li>*He had upper half side rails up on both sides of his bed.</li> <li>*He had not used his side rails for repositioning.</li> <li>*He was not able to reposition himself using his side rails.</li> <li>*He was observed lying flat on his back.</li> <li>*He had been bedbound for "quite some time."</li> <li>*He ate pleasure meals (small meals occasionally offered to residents with tube feedings for the pleasure of eating) in his room.</li> <li>*He had not eaten in the dining room since his tube feeding placement approximately two months prior to this survey.</li> <li>*He stayed in his room and had not participated in group activities or socialization with other residents.</li> <li>*He "rarely" moved from his bed to a wheelchair.</li> </ul> <p>Review of resident 2's care plan revealed: **"May have 1/2 side rails bilaterally for bed mobility." **"All meals in dining room." **"Provide opportunities for socialization with other residents on unit."</p> <p>2. Observation on 6/3/14 at 5:20 p.m. of resident 11 in the hallway by the dining room revealed: *He was in a wheelchair. *He had a contracture (permanent shortening of a muscle or joint) in his left arm and hand. *He was a smoker. *He stored his cigarettes and lighter by his right side on the wheelchair. *He left the dining hall twice in twenty minutes to smoke outside the exit door across from the dining room.</p>	F 280	<p>appropriate and as the facility staff learns more of the needs and preferences of the resident. The DON and the interdisciplinary team will review the care plan policy on June 27, 2014 to address cares cited in the deficiency. The DON or designee will maintain a list of admissions (new and readmits) and review their care plan when they are admitted as well as their regular schedules to monitor for 1/2 side rail use/ needs, smoking safety, and other changes that may indicate the necessity of updating the plan of care. The DON will present the data to the monthly QAPI Committee on July 16 2014 for their review and further recommendations.</p>	7/25/2014	

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F 280	<p>Continued From page 7</p> <p>*He had numerous burn holes in his clothing.</p> <p>Interview on 6/4/14 at 1:30 p.m. with resident 11 in his room revealed:</p> <p>*He had suffered a stroke in 2007 prior to his admission to the facility.</p> <p>*His stroke left him weakened on his left side.</p> <p>*He had been a long-time smoker.</p> <p>*He was allowed to keep his cigarettes and lighter in his wheelchair.</p> <p>*He was an unsupervised smoker and was allowed to come and go as he pleased to smoke.</p> <p>*He had never been assessed by staff regarding his ability to smoke without supervision or safety aides.</p> <p>Review of the care plan for resident 11 revealed:</p> <p>*A history of "self-neglect: ensure he is clean and odor free."</p> <p>*It had "paralysis: right arm and leg" marked with a check.</p> <p>*Listed "Hx [history] CVA [stroke] with hemiparesis [paralysis to one side of body]. Left side."</p> <p>**"Reposition resident per Turn Sheet [a sheet used by the facility to record repositioning changes for residents]."</p> <p>**Assess resident's ability to smoke safely."</p> <p>**Observe clothing and skin for signs of cigarette burns."</p> <p>Interview on 6/4/14 at 1:55 p.m. with the Minimum Data Set (MDS) coordinator regarding residents 2 and 11 revealed:</p> <p>*Care plans would auto-fill upon admission to the facility and were not individualized for residents or updated regularly or as needed by staff.</p> <p>*She would update care plans if staff notified her of a change but admitted it had rarely happened.</p>	F 280			

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F 280	Continued From page 8 *She agreed the care plans had not been revised and individualized by her or other staff for residents' current needs. *She had identified that to be a problem in the facility. *She agreed the care plans for the two above residents had not been updated or individualized. *She agreed not all items listed on the care plan were performed by staff, were accurate in care, or had been followed by staff. For example: -Resident 2 was unable to use his side rails for repositioning. -He had not eaten in the dining room. -Resident 11's care plan did not state he was allowed to keep his cigarettes or lighter with him at all times. -It had not stated how often he smoked or any limitations he had physically or mentally that would impair his ability to smoke safely. -His smoking assessment had "never been done." -It had not specified if staff were to accompany him or if he was able to smoke unsupervised. -He was not on a turn sheet as listed.  Review of the provider's June 2013 Care Plan Policy revealed: **"Care plans will be reviewed per federal and state regulations." **"Care plans will be individualized and unique to the resident." **"Care plans are updated as needed but a minimum of the admission care plan then quarterly after admission."	F 280			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility	F 281			

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F 281	<p>Continued From page 9 must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 A. Based on observation, interview, record review, and policy review, the provider failed to appropriately reposition eight of eight high risk residents (2, 16, 17, 18, 19, 20, 21 and 22) who were on a turn schedule for pressure ulcer prevention. Findings include:</p> <p>1. Random observations and interview on 6/3/14 and 6/4/14 between 8:00 a.m. and 6:00 p.m. of resident 2 in his room revealed: *He had a history of: -Diabetes. -Stroke. -Amputations to his lower extremities. -An enlarged heart. -High blood pressure. -A feeding tube. *He was observed lying flat on his back during each observation. *He had been bedbound for "quite some time." *He was not able to reposition himself. *He had a history of incontinence (unable to hold bowel and bladder contents).</p> <p>Interview on 6/4/14 at 1:40 p.m. with certified nursing assistant (CNA) B regarding resident 2's repositioning revealed: *She would reposition him according to the Turn Sheet [a sheet used by the facility to record repositioning changes for residents]." *The sheet was to be color coded according to how often the resident needed turning (red equaled two hours, white equaled three hours).</p>	F 281	<p>A.1. Resident #2 will have a Norton Plus Pressure Ulcer Assessment completed by the MDS Coordinator or designee on or before 7/23/2014 to determine the degree of risk the resident is at. Resident #2 is being repositioned at the highest risk protocol at the present time. Upon completion of the July assessment Resident #2 will be repositioned to the resident's needs. The DON or designee will review resident #2's turn records on a weekly basis for 4 weeks then monthly for the next three months to ensure compliance of the resident's needs. The DON will present the data to the monthly QAPI committee for their review and further recommendations. The MDS coordinator or designee will complete Norton Plus Pressure Ulcer Assessments on Resident #16, 17, and 18 on July 17, 2014, resident #19 on July 16, 2014; resident #20 on June 20, 2014; resident # 21 on or before 7/23/2014; and resident #22 on 7/15/2014, to determine the degree of risk the resident is at. Once the risk is identified, the residents listed above will be repositioned in accordance to the resident's needs. The DON or designee will review/audit the turn records of the above listed residents weekly for 4 weeks and then monthly for three months to ensure compliance of the resident's needs. The DON will present the data to the monthly QAPI committee for their review and further recommendations. The DON will re-educate the nursing staff on the policy and procedure regarding turning and repositioning those residents</p>	7/17/14	

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F 281	<p>Continued From page 10</p> <p>*She stated the nurse was responsible to tell her how and when to reposition a resident.</p> <p>Interview and Turn Record Sheet review on 6/4/14 at 1:55 p.m. with the Minimum Data Set (MDS) coordinator and the director of nursing (DON) regarding resident 2's repositioning revealed:</p> <p>*He was reportedly on a turn schedule program per his care plan.</p> <p>*He was to be turned every two to three hours and placed in a different position.</p> <p>*The MDS coordinator agreed when she reviewed his turn record sheet that he had not been repositioned appropriately.</p> <p>*Turn Sheet documentation showed he had been left on his back and had not been turned onto his left or right side.</p> <p>*The facility "has had the same policy for nine years and that is to reposition residents every two to three hours."</p> <p>*The Turn Sheet listed eight residents that were at high risk for pressure ulcers.</p> <p>*There had been no color coding system "for years" per the DON.</p> <p>*They were not sure what best practice recommendations currently were.</p> <p>*The MDS coordinator stated "no one updates the policy according to best practice," and she thought two to three hours was "okay." for high risk residents.</p> <p>*The DON stated she needed to do additional training for staff on repositioning as they were not doing it correctly.</p> <p>Review of the US Department of Health, Pressure Ulcer Prevention and Treatment Protocol, January, 2012, page 6 of 15, &lt;<a href="http://www.guideline.gov/popups/printView.aspx">http://www.guideline.gov/popups/printView.aspx</a></p>	F 281	<p>at risk of skin concern or pressure ulcers.</p> <p>The DON has revised the Repositioning Guidelines for the facility. Upon admission and quarterly thereafter, the Norton Plus Pressure Ulcer Scale will be completed by the MDS Coordinator of designee. Based on the resident's score, the resident's repositioning parameters will be set up. Each week at the weekly care conferences meeting, the scores and turn sheets will be reviewed and updated by the care conference team. The DON or designee will maintain a log of residents at risk for skin breakdown and monitor their turn sheets for accuracy and completeness 2-3 times per shift per week for 4 weeks. If they have been verified as accurate, the monitoring will be reduced to weekly spot checks by the licensed nurses. All monitoring logs will be submitted to the monthly QAPI committee for their review and further recommendations.</p> <p>b.1. Resident #4's restorative orders have been reviewed with resident #4's physician and at the present time the physician did not order restorative therapy for resident #4. The licensed nurse will communicate all restorative nursing orders via electronic notification to the therapy department and the DON for appropriate services ordered. The licensed nurse will document on the nurse communication board to follow-up with therapy within three days of the original order to ensure the orders have been carried out as ordered by the physician. THE DON or designee will log all therapy</p>	<p>7-17-14</p> <p>7-17-14</p>

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F 281	<p>Continued From page 11</p> <p>?id=36059&gt; revealed "If the patient is unable to shift weight independently, his/her position should be changed by care providers on an hourly basis."</p> <p>Review of the provider's August 2013 revised Pressure Ulcer Prevention Policy revealed: *"Nursing assistants are to reposition those residents on the list every two to three hours unless specified otherwise." *"Residents at risk are reviewed at the weekly at-risk meeting to determine if further interventions are needed." *The policy had not provided information to staff on how to appropriately reposition residents.</p> <p>Surveyor: 34030 Preceptor: 32335 B. Based on record review and interview, the provider failed to follow physician's orders to begin restorative therapy for one of one sampled resident (4) referred to restorative therapy. Findings include:</p> <p>1. Interview on 6/3/14 at 10:00 a.m. with resident 4 revealed she had not currently been doing restorative therapy but would have liked to.</p> <p>Review of resident 4's medical record revealed a physician's order dated 4/11/14 to begin restorative therapy.</p> <p>Interview on 6/4/14 at 9:25 a.m. with restorative aide N regarding resident 4 revealed: *She had not been receiving restorative therapy. *She had not been aware of the order dated 4/11/14 to start restorative therapy for the resident.</p>	F 281	<p>order communication and obtain documentation from therapy or licensed nurse as to the follow-up of said orders. The DON will audit all therapy order communications and follow-ups on a weekly basis for 4 weeks and then monthly for three months and present the data to the monthly QAPI committee for their review and further recommendations. The DON will update the policy and procedure in regards to communicating restorative nursing orders and re-educate the licensed nurses on the importance of responding to the physician's orders including the receiving, clarifying, and implementing physician's orders on June 26, 2014 with an in-house face to face inservice.</p>	7/25/2014

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F 281	Continued From page 12  Interview and record review on 6/4/14 at 3:00 p.m. with the infection control nurse revealed she: *Had signed off the order for restorative therapy for resident 4. *Had placed a copy of the order in the order box for the physical therapy department. *Was unaware the order had not been carried out and agreed it should have been followed up on.  Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 305, revealed: "Nurses follow health care providers' orders unless they believe the orders are in error or harm patients."	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Surveyor: 33488 A. Based on observation, interview, and record review, the provider failed to appropriately assess, monitor, and provide for safety for one of one sampled resident (11) who smoked. Findings include:  1. Random observations on 6/3/14 and 6/4/14 of	F 323	A.1. Resident #11 had a smoking assessment completed on July 9, 2014 by the MDS Coordinator to assess for smoking safety. Based upon the assessment, #11's care plan will be updated by the MDS Coordinator to reflect the current needs of the resident. The Smoking Assessment will be completed a minimum of quarterly by the MDS coordinator to determine if the resident's condition and plan of care remain accurate. All residents who smoke will have a smoking assessment completed by the MDS Coordinator or designee upon admission and then quarterly or with significant changes in conditions with their MDS assessment to ensure the information and plan of care remain accurate and current to the resident's needs. The DON will maintain a log of residents who smoke, smoking assessment dates, and review care plans to ensure completeness and accuracy.	DW 7-17-14

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F 323	<p>Continued From page 13</p> <p>resident 11 regarding his smoking revealed: *He would go outside the door across from the dining room to smoke. *He carried his cigarettes and a lighter in a container inside the right arm of the wheelchair adjacent to his wheelchair seat. *He was seen by three surveyors (32355, 32331, and 33488) to have several burn holes in his cotton pants. *He was unsupervised and wore no protective apron when he smoked.</p> <p>Interview on 6/4/14 at 1:35 p.m. with resident 11 in his room revealed: *He had been a long-time smoker. *He kept his cigarettes and lighter in his room on the wheelchair at all times. *He would smoke at any time he wished. *His brother rolled his own cigarettes for him at his home. *He stated he had gotten cigarette burns on his skin before. *He had a history of a stroke in 2007 which brought him to the facility.</p> <p>Review of the medical record for resident 11 revealed: *His care plan stated staff were to have assessed the resident's ability to smoke safely. *It also stated staff were to have observed clothing and skin for signs of cigarette burns. *His admission notes stated he was admitted in 2007. During that time he had been on a nicotine patch. *His history and physical signed by the admitting physician in December 2007 revealed "He has had a couple of incidents of falling asleep while smoking and burning his fingers and hands with lit cigarettes."</p>	F 323	<p>This log will be presented to the monthly QAPI committee for their review and further recommendations. All staff will be educated by the administrator and DON on the smoking assessment process and the responsibility of all staff to monitor and observe residents who smoke for hazards and report such hazards to the charge nurse for further assessment. The staff were educated on June 26, 2014 with an all staff inservice held in the facility. B.1. The Housekeeping staff have been re-educated by the Administrator on June 26, 2014 on the need to keep all housekeeping carts locked and keys removed from the lock when the carts are unattended. The Infection Control nurse or designee will conduct random checks of the housekeeping carts 2-3 times per week for 4 weeks and then weekly for 3 months to monitor compliance with securing the housekeeping carts. The Infection Control Nurse will present the monitoring logs to the monthly QAPI committee for their review and further recommendations.</p>	7/25/2014

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F 323	Continued From page 14  Interview and record review on 6/4/14 at 1:55 p.m. with the Minimum Data Set (MDS) coordinator and the director of nursing (DON) regarding resident 11's smoking revealed: *There had never been an assessment completed on the resident's ability to smoke safely. *After admission to the facility on an unknown date he resumed smoking. *They were unaware of the resident's previously unsafe smoking history. *They were unaware he had cigarette burns in his pants. *They were unsure how to assess the resident for safety. *They "assumed since the resident was oriented [aware of person, place, time and thing] that he would know to smoke safely." *They agreed that was an area of concern and the resident's safety was at risk. *They had no policy on smoking.  Surveyor: 34030 Preceptor: 32335 B. Based on observation and interview, the provider failed to secure chemicals in two of two observed housekeeping carts. Findings include:  1. Random observations on 6/3/14 and 6/4/14 revealed: *Housekeeping carts in the hallways on the main floor had been left unattended. *The key had been left in the lock on both carts. *The chemicals used for cleaning, including bleach, were inside the unlocked carts. *Multiple residents coming and going in the hallways where the unattended and unlocked	F 323		

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F 323	Continued From page 15 carts were.  Interview on 6/4/14 at 3:00 p.m. with the infection control nurse revealed: *She had expected the keys to have been secured. *No policy existed on the control of chemicals inside of housekeeping carts.	F 323		
F 431 SS=E	<b>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b>  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431	1. The DON re-educated the licensed nurses on the importance of keeping all medications carts locked when not attended and the necessity of keeping all keys to the locked boxes in the carts secured and not in the medication carts on June 26, 2014 with an inhouse, face to face inservice. 2. All keys that open locked boxes in the medication carts have been removed from the medication carts and placed on seperate key rings in which they are secure. 3.a. Resident #18's PRN lorazepam was counted by the DON on 6/7/2014 and a log sheet was placed with the card so that any licensed nurse that removes a dose must document on both the log sheet and the computerized Medication Administration Record to account for the dose being given. 3.b. Resident #24's PRN hydrocodone/APAP was counted by the DON on 6/7/2014 and a log sheet was placed with the card so that any licensed nurse that removes a dose must document on both the log sheet and the computerized Medication Administration Record to account for the dose being given. 3.c. Resident #23's PRN lorazepam was	<i>DN</i> 7-17-14  <i>DN</i> 7-17-14  <i>DN</i> 7-17-14

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F 431	<p>Continued From page 16</p> <p>abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Medications remained secure in one of four medication carts. *Security of the narcotic keys in four of four medication carts (main, north, upstairs, and memory care). *Accountability was maintained for controlled and highly diverted (stolen) medications for three of five random reviewed residents (18, 23, and 24) who received PRN (as needed) schedule III and IV (government controlled) medications. Findings include:</p> <p>1. Observation on 6/3/14 from 1:57 p.m. through 2:10 p.m. of a medication cart revealed: *The medication cart had been located in the hallway by the receptionist's desk. *There had been no nursing staff located by the cart. *The medication cart had been unlocked and was easily accessed by two surveyors. *There had been an unidentified staff person sitting approximately ten feet from the medication cart. *Several unidentified residents had been going past the medication cart. *Multiple unidentified staff members had walked past the medication cart.</p>	F 431	<p>counted by the DON on 6/7/2014 and a log sheet was placed with the card so that any licensed nurse that removes a dose must document on both the log sheet and the computerized Medication Administration Record to account for the dose being given. The DON will re-educate the licensed nurses on the necessity of securing and accounting of Schedule III and IV medications. The DON has updated the policy on Schedule III and IV medications to include the log sheet as well as the computerized Medication Administration Record to account for each schedule III and IV PRN drugs.</p> <p>d. 3.d. The Administrator contacted law enforcement and Pharmacy management on June 5, 2014 to report the alleged drug diversion. The DON or designee will perform reviews of the schedule III and IV drugs and their logs with the Medication Administration Records of residents #18, 23, and 24 as well as at least 10% of all other schedule III and IV PRN drugs to ensure all doses are being documented for each resident. The logs will be reviewed on a weekly basis for 4 weeks and then monthly for three months. The DON will present the data to the QAPI committee for their review and further recommendations. The DON updated the policy for Schedule III and IV drug storage/administration on June 7, 2014.</p>	7/25/2014

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F 431	<p>Continued From page 17</p> <p>*At 2:10 p.m. registered nurse (RN) H had retrieved an item from the medication cart and locked it.</p> <p>Interview on 6/3/14 at 2:10 p.m. with RN H revealed she:</p> <p>*Had not been aware the medication cart had been left unlocked.</p> <p>*Confirmed the medication cart should have been locked when unattended.</p> <p>Interview on 6/4/14 at 2:45 p.m. with the Minimum Data Set (MDS) coordinator confirmed the medication cart should have been locked when unattended.</p> <p>Review of the provider's 1/1/13 LTC (long-term care) Facility's Pharmacy Services and Procedures manual confirmed the medication cart should have been locked when unattended.</p> <p>2. Observation and interview with the MDS coordinator on 6/4/14 from 3:00 p.m. through 3:30 p.m. of four medication carts revealed:</p> <p>*All four carts had a keypad with numbers.</p> <p>*A certain code had to be entered on the keypad to open the medication carts.</p> <p>*All of the nurses in the facility had access to those codes.</p> <p>*A single key had been located in the top drawers.</p> <p>*Each cart contained a locked box in the bottom drawer.</p> <p>*The keys opened the locked boxes.</p> <p>*Inside of the locked boxes had been scheduled II medications.</p> <p>*The MDS coordinator had not been concerned with the availability of those keys to all the nursing staff.</p>	F 431			

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F 431	<p>Continued From page 18</p> <p>*She had confirmed the key should have been only accessible to the nurses passing the medications.</p> <p>Review of the provider's 1/1/13 Pharmacy Services and Procedures Manual for Storage of Medications revealed the "Facility should ensure that all controlled substances are stored in a manner that maintains their integrity and security."</p> <p>3a. Observation on 6/4/14 at 3:40 p.m. of the main wing's medication cart revealed: *Resident 18 had a blister pack (pre-formed plastic packaging) for as needed (PRN) lorazepam (controlled medication for nervousness). *The medication card had been filled by the pharmacy on 8/29/13 with thirty tablets. *There were four tablets remaining in the medication card. *There were ten tablets missing from the medication card that had not been documented as administered on the medication administration record (MAR).</p> <p>b. Observation on 6/4/14 at 4:10 p.m. of the upstairs medication cart revealed: *Resident 24 had a blister pack for PRN hydrocodone/APAP (acetaminophen) (controlled medication for pain). *The medication card had been filled by the pharmacy on 5/24/14 with thirty tablets. *There were fourteen tablets remaining in the medication card. *There were three tablets missing from the medication card that had not been documented as administered on the MAR.</p>	F 431		

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F 431	<p>Continued From page 19</p> <p>c. Observation on 6/4/14 at 4:50 p.m. of the north wing's medication cart revealed: *Resident 23 had a blister pack for PRN lorazepam. *The medication card had been filled by the pharmacy on 5/22/14 with thirty tablets. *There were five tablets remaining in the medication card. *There were six tablets missing from the medication card that had not been documented as administered on the MAR.</p> <p>d. Interview on 6/4/14 at 5:20 p.m. with the MDS coordinator and the director of nursing revealed: *They had no formal process in place to account for the controlled schedule III and IV medications. *They had not performed an actual individual count on each schedule III and IV medication. *The nurses had only been required to account for the scheduled II medications.</p> <p>Review of the provider's 1/1/13 Pharmacy Services and Procedures for Inventory Control of Controlled Substances revealed: **Facility should ensure that facility staff count all schedule III-V controlled substance in accordance with facility policy and applicable law." **Facility should periodically count controlled substances stored in emergency kits, refrigerators or kept in other storage areas." **Facility should ensure that all controlled substances are stored in a manner that maintains their integrity and security."</p> <p>Review of the provider's 12/1/07 Pharmacy Services and Procedures Manual for Loss or Theft of Medications revealed: **Notify the appropriate facility administrator of controlled substance discrepancies, and if such</p>	F 431		

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F 431	Continued From page 20 discrepancies are not reconciled, notify the appropriate law enforcement agencies according to applicable law and facility policy."  Interview on 6/5/14 at 8:50 a.m. with the administrator revealed the local law enforcement and pharmacy had not been contacted. The provider had no other policy or process other than the above in place to follow for possible drug diversion.	F 431		
F 441 SS=E	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441	<p>*The waiver provides education regarding potential risks of infection while bathing with a catheter. SD/DOH/MF</p> <p>1. The Infection Control nurse and DON will re-educate the nursing staff on the proper procedure for cleaning and disinfecting the whirlpool tub on June 26, 2014. The inservice will be for all nursing staff and take place inhouse, face to face inservice. The Infection Control Nurse or designee will conduct random checks of the whirlpool cleaning process 2-3 times per week for 4 weeks and then weekly for 1 month to ensure nursing staff is properly cleaning and disinfecting the whirlpool per policy. The Infection Control nurse will submit the logs to the QAPI committee for their review and further recommendations at their monthly meeting on July 16, 2014.</p> <p>2. The Infection Control Nurse and DON educated the nursing staff on the revised Whirlpool bathing for residents with Foley catheters policy per SD DOH survey 6/5/2014. A Waiver for the whirlpool bath form has been made for any residents who wish to decline the recommendations.*</p> <p>* [REDACTED] A&amp;L education took place on [REDACTED] June 26, 2014 with a nursing inservice.</p>	

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F 441	<p>Continued From page 21</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Preceptor: 32335 Based on observation, interview, policy review, and manufactures' instructions, the provider failed to: *Properly disinfect one of two whirlpool tubs located in the west hallway. *Ensure education and processes were in place for bathing of all residents with a Foley catheter (a tube inserted into the bladder to drain urine) for one of two residents (26). *Ensure treatment supplies for multiple residents were not co-mingled in four of four medication carts. *Ensure proper handwashing and glove use by staff for one of two observed meal services. Findings include:</p> <p>1. Observation and interview on 6/3/14 at 3:15 p.m. with certified nursing assistant (CNA) I revealed she: *Was the main bath aide. *Had been trained by the sales staff three years ago on the cleaning of the whirlpool tub. *Rinsed the tub with water then filled it per the</p>	F 441	<p>3. The DON will re-educate the licensed nurses on June 26, 2014 on the proper storage of items in the medication carts. The DON will complete random checks of all medications carts twice weekly for 4 weeks and then monthly for three months to ensure the contents are stored properly. DON will present the data to the monthly QAPI committee for their review and further recommendations, on July 16, 2014.</p> <p>4 and 5. The DON and Infection Control nurse will re-educate nursing staff on proper handwashing and glove use in the dining room. The Infection Control nurse or designee will monitor the handwashing and glove use of CNA "J" and "C" in the dining room to review compliance of proper handwashing 2-3 times per week for 4 weeks. All staff will be observed by the INfection Control Nurse or designee during meal time 2-3 times per week per meal for 4 weeks to monitor compliance on proper handwashing and glove use in the dining room. The Infection Control Nurse will present the logs to the monthly QAPI committee for their review and further recommendations.</p>	<p>7/25/2014</p> <p><i>Handwritten initials and date: JN 7-17-14</i></p>

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F 441	<p>Continued From page 22</p> <p>manufacture's instructions with the Penner whirlpool cleanser (disinfectant). *Scrubbed the tub with the disinfectant solution, left it on for approximately one minute, then rinsed it off. *Left the whirlpool swivel lift chair outside of the tub, sprayed it with the above disinfectant, then wiped it down. *Stated that was the procedure she used to clean the tub in between residents.</p> <p>Review of Penner Manufacturing daily maintenance instructions on system cleaning after every bath revealed the: *Chair should have been placed in the tub for cleaning. *Disinfectant should have been left on the surface for ten minutes before rinsing it off. *Air blower should have been used to push the rinse water out of the air injection system.</p> <p>Interview on 6/4/14 at 3:00 p.m. with the infection control RN revealed: *She agreed the manufacturer's instructions for the cleansing of the whirlpool tub had not been followed.</p> <p>2. Interview on 6/3/14 at 3:15 p.m. with CNA I revealed she bathed residents with a Foley catheter submerged in the whirlpool tub.</p> <p>Interview on 6/4/14 at 3:00 p.m. with the infection control RN revealed: *No policy or procedure existed for bathing residents with a Foley catheter. *She agreed bathing of residents with Foley catheters submerged in the tub had not been a good practice.</p>	F 441		

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F 441	<p>Continued From page 23</p> <p>According to the National Institute of Health website "bathing residents with a Foley catheter submerged in a tub is not recommended." <a href="http://www.cc.nih.gov/ccc/patient_education/prepubs/bladder/foley5_17.pdf">http://www.cc.nih.gov/ccc/patient_education/prepubs/bladder/foley5_17.pdf</a>.</p> <p>Surveyor: 32355</p> <p>3. Observation on 6/4/14 from 3:00 p.m. through 4:00 p.m. of all four medication carts (main, north, upstairs, and memory care) revealed multiple resident treatment supplies co-mingled together. Those treatment supplies were:</p> <ul style="list-style-type: none"> <li>-Multiple tubes of Calmoseptine ointment (used on irritated or reddened skin).</li> <li>-Several bottles of Biofreeze gel (pain reliever).</li> <li>-Several tubes of moisture barrier (protectant cream for skin).</li> <li>-One bottle of Nystop (powder used for fungal infections).</li> <li>-One tube of Bengay ointment (pain reliever).</li> <li>-One tube of Vaseline (moisturizer).</li> <li>-Several bottles of body lotion.</li> </ul> <p>Interview on 6/4/14 with the Minimum Data Set (MDS) coordinator at the time of the observation confirmed the treatment supplies should have been separated. There had been potential for cross-contamination.</p> <p>No policy had been provided when requested from the MDS coordinator on the proper storage of treatment supplies.</p> <p>Surveyor: 32335</p> <p>4. Observation on 6/3/14 at 6:10 p.m. of CNA J in the main dining room revealed she:</p> <ul style="list-style-type: none"> <li>*Walked into the dining room from the hallway.</li> <li>*Went to the serving line and spoke to the cook.</li> </ul>	F 441	

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F 441	<p>Continued From page 24</p> <ul style="list-style-type: none"> <li>*Turned and walked away.</li> <li>*Grabbed an apron, put it on, and tied the strings in the back.</li> <li>*Sat down at a table to assist four residents.</li> <li>*Grabbed the half banana and peeled it for one resident.</li> <li>*Touched the ketchup bottle, her hair, and silverware being used by another resident.</li> <li>*Had not washed her hands or used sanitizer during any of that observation.</li> </ul> <p>Surveyor: 16385</p> <p>5. Observation of the evening meal service on 6/3/14 at 6:15 p.m. revealed:</p> <ul style="list-style-type: none"> <li>*CNA C was assisting resident 25 with his meal.</li> <li>*CNA C was wearing protective gloves.</li> <li>*Resident 25 had asked CNA C to reposition his legs.</li> <li>*CNA C had removed her gloves and repositioned resident 25's legs.</li> <li>*CNA C then put on the same gloves without washing her hands or using hand sanitizer.</li> </ul> <p>Interview on 6/4/14 at 5:00 p.m. with the infection control nurse revealed CNA C should have washed her hands or used hand sanitizer after repositioning the resident. She stated CNA C should have put on new gloves.</p> <p>Review of the provider's February 2012 Handwashing/Hand Hygiene policy revealed:</p> <ul style="list-style-type: none"> <li>**5. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial soap and water under the following conditions:             <ul style="list-style-type: none"> <li>-c. Before and after direct resident contact."</li> </ul> </li> <li>**6. When to Use Alcohol-Based Hand Rub.             <ul style="list-style-type: none"> <li>-a. Before and after direct contact with a resident.</li> <li>-b. Before donning sterile gloves."</li> </ul> </li> </ul> <p>Review of the provider's undated Personal</p>	F 441		

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F 441	Continued From page 25 Protective Equipment - Gloves policy revealed: **2. Gloves shall be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed."	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to ensure staff had readily accessible access to all of the residents' care plans for one of two floors (upstairs). Findings include:  1. Observation on 6/3/14 at 10:50 a.m. revealed: *All the care plans including those for the second floor (upstairs) residents were located in the nurses' station on the main or first floor. *The care plans were in a black binder marked with a handwritten label Care Plan Upstairs	F 514	The DON will re-educate the nursing staff on the care plans on June 26, 2014 with an in-house face to face inservice. The DON has developed a pocket care plan form for residents on all care locations, including upstairs, that contain pertinent care information for the residents including Room #, Resident name, nutrition needs, bowel and bladder, transfer/mobility, safety (Fall devices, smoking, elopement), Cognition/Behavior, Sensory Devices/Dentures, Skin Care/Pressure Ulcer, and any other special instructions. The DON will update the Care Plan policy to reflect the utilization of the pocket care plan.  The care plan team will review the pocket care plans at their weekly interdisciplinary care plan team meetings. THE DON will audit the usage and the updating of the pocket care plans on a weekly basis for 4 weeks and then monthly for three months and present the data to the monthly QAPI committee meeting for their review and further recommendations. The QAPI meeting will be held July 16, 2014 and August 18, 2014.	7-17-14  7/25/2014

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F 514	<p>Continued From page 26</p> <p>Interview on 6/3/14 from 2:00 p.m. through 2:10 p.m. with certified nursing assistants (CNA) E, F, and G regarding residents located upstairs revealed:</p> <ul style="list-style-type: none"> <li>*There were no care plans located on the second floor.</li> <li>*If there were questions regarding a resident's care the charge nurse on the first floor would have needed to be called.</li> <li>*If the charge nurse was unavailable another CNA would have been asked regarding a resident's care.</li> <li>*A white board in the nurses report room on the first floor contained information that had needed to be read before working with residents upstairs.</li> <li>*They stated that communication needed to be improved.</li> </ul> <p>Observation on 6/4/14 at 5:00 p.m. in the nurses report room on the first floor revealed:</p> <ul style="list-style-type: none"> <li>*An approximately two foot by two foot white board with the following handwritten headings: <ul style="list-style-type: none"> <li>-I and O (Intake and Output).</li> <li>-EZ stand (equipment used to assist a resident with standing).</li> <li>-Mech [mechanical] lift (equipment used to transfer a resident from one surface area to another).</li> </ul> </li> <li>*The white board was attached to the wall.</li> <li>*There was a handwritten column on the white board under the above listed headings for residents upstairs.</li> <li>*There were four residents listed for an I and O and seven residents listed for an EZ stand.</li> <li>*An approximately twelve inch by eighteen inch sheet of paper on a clipboard with the following handwritten headings: <ul style="list-style-type: none"> <li>-Main.</li> </ul> </li> </ul>	F 514		

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F 514	<p>Continued From page 27</p> <p>-North. -Upstairs. -Other. *The above clipboard was laying on the counter. *There was a section on the bottom of the paper for placement of staff initials. *There were two residents listed under "Upstairs" with information.</p> <p>Surveyor: 32332 Interview on 6/5/14 at 11:35 a.m. with CNA O revealed: *The CNAs who worked on the second floor did not have information with them to indicate how the residents were to have been cared for. *Staff, including temporary workers (those who come from an employment agency) would have to read through the care plans or call the charge nurse to obtain that information. *The care plans remained on the first floor.</p> <p>Interview on 6/5/14 at 3:30 p.m. with the nurse aide trainer revealed when asked how staff on the second floor knew how to take care of the residents reported: *Some information would have been on the wall-mounted kiosk (a computer terminal), but it had not included information specific to each resident. *The Palm Pilot (a hand-held device the CNAs used to document care given) had not contained that information. *The care plans for the second floor should have been readily available to the staff working there.</p> <p>Interview on 6/4/14 at 3:00 p.m. with the Minimum Data Set coordinator revealed: *CNAs used the report board in the report room on the first floor to obtain any information on how</p>	F 514		

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F 514	<p>Continued From page 28</p> <p>to care for residents, including those on the second floor.</p> <p>*The CNAs had not received any verbal report before providing care.</p> <p>*The wall kiosk was capable of being updated to include individualized information on caring for the residents, but it was not currently being utilized.</p> <p>Review of the provider's June 2013 Care Plan Policy revealed:</p> <p>*The purpose was to promote resident centered care for each person who resided in the facility.</p> <p>*The care plans were to have been developed by all disciplines to promote communication in providing each resident's care.</p> <p>Review of Patrician A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013, p. 262, regarding interdisciplinary care plans revealed "Unless communication is timely and accurate, caregivers can be uninformed, interventions may be duplicated needlessly, procedures may be delayed, or tasks may be left undone."</p>	F 514			

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

**ORIGINAL**

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/04/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>TIESZEN MEMORIAL HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>312 EAST STATE ST MARION, SD 57043</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 06/04/14. Tieszen Memorial Home was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 06/04/14 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 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1  This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain the one hour fire resistive rating of vertical openings.	K 033		

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

TITLE

(X6) DATE

*Anna Wilson*

*Administrative* RECEIVED 6/27-14

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/04/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>TIESZEN MEMORIAL HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>312 EAST STATE ST MARION, SD 57043</b>	
(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 033	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>* The west stair enclosure walls did not extend to the underside of the roof deck of the 1976 addition.</li> <li>*The north basement stair enclosure door was equipped with a twenty minute fire resistive door assembly.</li> <li>*The east and west stair enclosure doors were not provided with labels and contained glass vision panels.</li> </ul> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Observation at 9:00 a.m. on 06/04/14 revealed a twenty minute fire resistive door assembly had been installed in the north stair enclosure from the basement. Review of the previous life safety code survey revealed the original 1 3/4 inch metal door had been replaced with the present door approximately eight years ago.</li> <li>2. Observation at 9:30 a.m. on 06/04/14 revealed the upper and lower east and the upper west stair enclosure doors had not been provided with labels to identify the fire resistive rating. The upper and lower east stair enclosure doors had been equipped with a 35 by 21 inch vision panel. Review of the previous life safety code data identified that had been part of the original construction.</li> <li>3. Observation at 10:30 a.m. on 06/04/14 revealed the west stair enclosure walls did not extend to the underside of the roof deck. Further observation revealed the exterior window was exposed to the 1976 addition roof. Review of the previous life safety code data identified that had been part of the original construction.</li> </ol> <p>This deficiency affected the second floor smoke compartment and between twelve to fourteen</p>	K 033		F

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/04/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>TIESZEN MEMORIAL HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>312 EAST STATE ST MARION, SD 57043</b>	
(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 033	Continued From page 2 residents.	K 033		
K 034 SS=C	<p>The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiency identified in K000.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation, measurements, and record review, the provider failed to maintain conforming exit stairs (west stair enclosure). Findings include:</p> <p>1. Observation and measurement at 11:30 a.m. on 06/04/14 revealed the tread widths for the stairs in the west stair enclosure varied from 9 1/2 to 12 inches between adjacent stairs. Review of previous survey data identified that condition had been part of the original construction.</p> <p>This deficiency affected the second floor smoke compartment and between twelve to fourteen residents.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiency identified in K000.</p>	K 034		F

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PRINTED: 06/16/2014  
FORM APPROVED

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10647</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/05/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>TIESZEN MEMORIAL HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>312 E STATE ST MARION, SD 57043</b>
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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
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S 000	Initial Comments  Surveyor: 32332 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 6/3/14 through 6/5/14. Tieszen Memorial Home was found not in compliance with the following requirement: S166.	S 000	<i>Addendums noted with an asterisk per 7/11/14 telephone to facility administrator. SDSDOH/IMF</i>	
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		

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

*Anna Wilson*

STATE FORM

021199

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DATE 6-27-14  
JUN 30 2014  
SD DOH L&C

continuation sheet 1 of 3

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10647</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/05/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>TIESZEN MEMORIAL HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>312 E STATE ST MARION, SD 57043</b>
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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
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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 Rule is not met as evidenced by: Surveyor: 34030 Preceptor: 32335 Based on observation, interview, and policy review, the provider failed to ensure four of four unattended exit doors were alarmed during the day. Findings include:</p> <p>1. Random observations on 6/3/14 and 6/4/14 revealed: *From 8:00 a.m. to 5:30 p.m. the door alarms had not activated for the front east, the front west, and the two exits at the wellness center department area. *One of the two exit doors by the wellness center had not been visible from there. *Multiple residents had been moving about independently in the halls by the doors.</p> <p>Observation on 6/4/14 at 9:25 a.m. in the wellness center department revealed: *Restorative aide N had been working with a resident with her back to the doors. *A second random staff had been in the office working on charts with his back to the doors.</p>	S 166	<p><i>omit dw</i></p> <p>The facility will install a monitor at the nurse's station in which all unattended exit door cameras will have the exit doors in view and can be monitored by the charge nurse in the facility.</p> <p>7/25/2014</p> <p>The facility will install a monitor at the receptionist's desk in which all unattended exit door cameras will have the exit doors in view and can be monitored by the receptionist from 8:30-5 daily* When the receptionist is not on duty, the doors will be alarmed and locked.</p> <p>7/25/2014</p> <p><i>*see page 3 SD/SDDH/ME</i></p>	
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*\*monitored through Friday 5:30-7:00 PM*

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10647</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>TIESZEN MEMORIAL HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>312 E STATE ST MARION, SD 57043</b>		
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S 166	Continued From Page 2  Interview on 6/4/14 at 2:10 p.m. with the maintenance supervisor revealed: *Time schedules for the door alarms had been posted by the exit doors. *The four unattended doors were locked from 9:00 p.m. to 7:00 a.m. *He stated the doors were left unattended and unalarmed during the day but would alarm for residents with Wander guards that left the building.  Interview on 6/4/14 at 2:35 p.m. and at 4:15 p.m. with the administrator revealed she: *Stated there were cameras on the exit doors but admitted they had not been monitored on a regular basis. *Stated the wellness center department monitored the two exit doors in that hall. *Did not agree exit doors needed to be alarmed during the day.  Review of the door alarm policy dated August 2013 revealed: **"The Tieszen Memorial Home, Inc. has installed a security system for all exterior doors to the facility. The locking and unlocking of the doors is controlled via computer and can be adjusted per facility needs. This system also provides for an opportunity to "lock-down" the entire facility with a single button." **"All exterior doors are also equipped with the wandergaard system for those residents who have been identified as exit-seeking to alarm in the event a resident attempts to exit." **"All exterior exits are also equipped with a recordable camera system so anyone entering or leaving the facility is recorded."	S 166	* Installation of the equipment has been set for 6/5/14. The charge nurse will be auditing the doors daily after 5:00pm until the equipment has been installed. After installation, the charge nurse will audit the doors for active alarms weekly for one month, then monthly. The administrator will be updating the door alarm policy to reflect the changes, and will communicate changes to all staff by written communication, with an attached door alarm policy. <i>SP/SS/CH/MT</i>	