

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

**ORIGINAL**

PRINTED: 09/30/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/17/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BENNETT COUNTY HOSPITAL AND NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>102 MAJOR ALLEN POST OFFICE BOX 70 MARTIN, SD 57551</b>
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F 000	INITIAL COMMENTS  Surveyor: 32333 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/15/14 through 9/17/14. Bennett County Hospital and Nursing Home was found not in compliance with the following requirements: F164, F248, F280, F281, F282, F315, F323, F364, F371, F441, and F514.	F 000	Addendums noted by an asterisk per 10/20/14 telephone to facility administrator. JAKSDOCH/MF	
F 164 SS=B	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.  The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another	F 164	F164 Completion Date: 10/14/2014  All staff will be educated on resident rights by the ombudsman on 10/14/2014.  *will JAKSDOCH/MF  The DON or designee review this process twice a week, observing med passes and treatments to assure privacy is maintained. Findings will be reported to the QA committee by the DON monthly for the first quarter and then quarterly per QA findings.  *including WAP A and LCN B JAKSDOCH/MF	10/14/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Edith Masten</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10/14/14</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

**RECEIVED**

**OCT 16 2014**

If continuation sheet Page 1 of 4

**SD DOH L&C**

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F 164	<p>Continued From page 1 healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation and interview, the provider failed to ensure resident-specific medical information was kept confidential on the following: *Medication administration records (MAR) by one of two unlicensed assistive personnel (UAP) (A) during one of two observed medication passes. *Treatment administration records by one of one licensed practical nurse (LPN) (B) during two of two observed dressing changes. Findings include:</p> <p>1. Observation on 9/15/14 from 5:30 p.m. to 5:47 p.m. revealed UAP A administered medications to six residents. During each of those administration times she left the MAR open to resident-specific information. The cart was in the dining room during that time. Multiple residents, staff, and visitors walked by that cart on the way in and out of the dining room.</p> <p>2. Observation on 9/16/14 from 7:15 a.m. through 7:30 a.m. revealed LPN B completed blood sugar checks on three residents. She placed the treatment cart outside of the resident's door. The resident's treatment record was open to resident-specific information on the top of that cart. She did not close the treatment record when she had entered a resident's room and shut the door behind her. That information was left unattended in a hallway used by resident's, visitors, and staff while she was in the residents' rooms.</p>	F 164		

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F 164	Continued From page 2  Surveyor: 32333 3. Observation on 9/16/14 at 10:45 a.m. of LPN B while she had been gathering supplies to perform a dressing change on resident 6 revealed she: *Pushed her treatment cart outside of the resident's room door. *Opened and reviewed her treatment administration record (TAR) book that was on top of the treatment cart. *Gathered her supplies from her cart. *Entered the resident's room and closed the door behind her. *Was in the resident's room for about fifteen to twenty minutes. *Had left the TAR open and on top of her cart while she had been in the resident's room. *That cart was in a hallway used by residents, visitors, and staff.  Surveyor: 32572 4. Observation on 9/16/14 at 2:07 p.m. revealed: *LPN B had placed the treatment cart outside of resident 12's room in hallway B. *She had the TAR open to resident 12's physician ordered treatment. *She gathered her supplies, and then went into the resident's room and shut the door. *She performed the treatment, and then opened the door to reveal the TAR had remained open. *During that time residents and visitors had been in that hallway.  5. Interview on 9/17/14 at 8:00 a.m. with the director of nursing confirmed she would have expected the resident's medical records (MAR and TAR) to have remained closed and not visible	F 164		

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F 164	Continued From page 3 to anyone.	F 164		
F 248 SS=D	<p>Review of the admission packet revealed resident identifiable information would be maintained in a confidential manner.</p> <p><b>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</b></p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on interview and record review, the provider failed to ensure: *An effective activity program had been developed and implemented for all residents within the facility. *Activities for two of nine sampled residents (6 and 9) had been care planned. *A one-to-one activity program had been developed and implemented for one of one sampled resident (9) requiring a one-to-one activity program. Findings include:</p> <p>1. Group interview on 9/16/14 at 10:00 a.m. with seven residents in attendance revealed : *There was not a lot of attendance at activities except for bingo. *They would like some more different activities than the ones currently being offered. *They would like more outings (activities outside</p>	F 248	<p>F 248 Completion Date: 11/06/2014</p> <p>Resident 6's and 9's care plan was updated by the Activities Director to include an activities care plan that was individualized and comprehensive.</p> <p>All resident charts will be reviewed by the Activities Director to assure they all have activities care plans that are individualized, comprehensive, and up to date.</p> <p>Residents who would benefit from 1:1 activities will be identified by the Activities Director and DON and care plans will be created to meet their needs.</p> <p>The Activities Director will provide activities every weekend and one evening a week. The Activities schedule will be revised to include more activities as well as an alternate activity during the time Catholic Church is scheduled. Care plan meeting will be removed from the Activities care plan.</p>	11/06/14

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F 248	Continued From page 4 of the facility).  Review of the June, July, August, and September 2014 activity calenders revealed: *June: -No activities had been provided after 3:30 p.m. -No activities had been scheduled on Saturday 6/7/14, 6/21/14, or 6/28/14. -On every Tuesday of the month at 9:00 a.m. "Care Plan Mtg.[meeting]" had been scheduled. -Every Thursday of the month at 9:30 a.m. "Catholic Church" had been the only morning activity scheduled. *July: -No activities had been provided after 3:30 p.m. -No activities had been scheduled on Saturday 7/5/14, 7/12/14, or 7/26/14. -On every Tuesday of the month at 9:00 a.m. "Care Plan Mtg.[meeting]" had been scheduled. *September: -No activities had been scheduled after 3:00 p.m. -Movie and popcorn had been the only scheduled activity on every Saturday of the month. -On every Tuesday of the month at 9:00 a.m. "Care Plan Mtg.[meeting]" had been scheduled. -Every Thursday of the month at 9:30 a.m. "Catholic Church" had been the only morning activity scheduled except for on 9/4/14. -On 9/1/14, 9/3/14, and 9/8/14 no afternoon activities had been scheduled. *No August schedule had been provided for review.  2. Review of resident 6's current undated care plan revealed no mention of activities. Refer to F280, finding 3.  Surveyor: 32573 3. Interview on 9/17/14 at 8:45 a.m. with the	F 248	All Nursing staff will be instructed on how to document on resident activities in the absence of the Activities Director.  The Occupational Therapist of designee will QA the activities department for compliance, reviewing 25% of resident charts monthly to assure care plans are individualized, comprehensive, and up to date. This will be done monthly for the first quarter and then quarterly per QA findings.  The Occupational Therapist or Designee will QA Resident council meetings to assure they are done on a monthly basis. This process will occur monthly for the first quarter and then quarterly per QA findings.  The Activities Director or designee will have all residents who are able to complete a resident satisfaction survey for activities monthly for the first quarter and then quarterly as per QA findings. The Activities Director will report findings to the QA committee.  <i>*these JASDDDHMF</i>	

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F 248	<p>Continued From page 5</p> <p>activities director revealed she had not been sure what activities to do with resident 9. He had not been on a one-to-one plan, but she wanted to get him on one. She had not previously had time to include him in one-to-ones because of the number of other residents on one-to-one programs. She did not have any specific activity plans created for residents under 55 years old. Refer to F280, finding 6.</p> <p>4. Interview on 9/16/14 at 2:05 p.m. and on 9/17/14 at 9:30 a.m. with the activities director revealed:</p> <ul style="list-style-type: none"> <li>*Only one resident had been on a one-to-one activity program.</li> <li>*She had been out of work for two weeks in August due to illness.</li> <li>*There had been no resident council in August due to the activity director being out ill.</li> <li>*She was the only employee in the activity department.</li> <li>*No one had fulfilled her duties while she had been ill.</li> <li>*There had been no scheduled activities on Saturdays.</li> <li>*No activities had been scheduled on Sundays except volunteer church services.</li> <li>*All residents should have had activities careplanned.</li> </ul> <p>Surveyor: 32333</p> <p>5. Interview on 9/17/14 at 10:35 a.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> <li>*She agreed activities should have been on all of the residents careplans.</li> <li>*Activities should have been scheduled on weekends and evenings.</li> <li>*A resident council meeting should have been offered to the residents in August 2014.</li> </ul>	F 248	<p>The Activities Director and the Occupational Therapist will develop activity plans for residents under age 55.</p> <p>The interdisciplinary team and nursing staff will be inserviced on this process by 11/06/2014.</p> <p>Findings will be reported to the QA committee by the DON monthly for the first quarter and then quarterly per the QA committee findings.</p>	

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F 248	Continued From page 6	F 248			
F 280 SS=E	<p>Surveyor: 32573</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</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: 32572 Based on observation, interview, record review, and policy review, the provider failed to ensure care plans reflected the residents' current status for six of nine sampled residents (1, 2, 5, 6, 8, and 9). Findings include:</p> <p>1. Review of resident 1's medical record revealed she had been receiving restorative therapy (RT)</p>	F 280	<p>F 280 Completion Date: 11/06/2014</p> <p>Resident 1 will have a large face clock in her room and a current monthly calendar large enough for her to read. CP will be updated by DON or designee to note current therapies.</p> <p>Resident 5 will be evaluated by the Activities director to see what her activities preference is. She will then be encouraged to participate in activities or 1:1 activities. This process will be QA'd by the Activities Director or designee monthly for the first quarter and then quarterly per QA findings. Activities director will report findings to QA committee.</p> <p>Resident 5's care plan will be updated by DON or designee to note current conditions and care needed. She will receive dietary supplements and be set at the feeder table where staff will encourage appropriate intake and assist as needed. This process will be monitored 3 times a week by the DON to assure CP is being followed and resident has appropriate intake. Resident's weight will be monitored</p>	11/06/14	

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F 280	<p>Continued From page 7 services.</p> <p>Review of resident 1's care plan revealed: *A revised 7/22/14 focus area of "Resident has scored a 10 on the BIMS (mental examination)..." -A score of 10 on the BIMS indicates moderately impaired thought processes. *The goal had been "The resident will maintain current level of cognitive [thought] function through the next care plan review date. *An intervention had been "Ensure that a large face clock is in her room with the correct time, and a current monthly calander [calender] with the correct day, month, and year to help maintain orientation to day and time." *A revised 7/22/14 focus area for "mobility impairment r/t (related to) medical DX (diagnosis)... Resident was evaluated for PT (physical therapy) on 4/23/14 and has PT 2 days a week." *The goal had been "The resident will maintain current level of mobility with evidence of decline in present status while participating with RT (restorative therapy) by doing ..." *An intervention had been "Resident to participate with PT per PT recommendations (2 times a week) until further notice."</p> <p>Random observations from 9/15/14 at 1:45 p.m. through 9/17/14 at 10:45 a.m. revealed a clock hanging on the wall in resident 1's room with a clock face that was eight inches in diameter. That clock had been across the room and toward the foot of her bed. Also in the room the activity calendar had been posted at the head of her bed on the cork board. The calendar had a picture on the top third of the page, and the scheduled activities on the bottom two-thirds of the page. The print on that calendar was small.</p>	F 280	<p>weekly by the DON. Findings will be reported by the DON to the QA committee monthly for the first quarter and then quarterly per QA findings.</p> <p>An activities care plan that is individualized, comprehensive and up to date will be developed for resident 6 by the Activities director.</p> <p>Resident 8's care plan will be reviewed to assure it is individualized, comprehensive and up to date. The diagnosis of VRE will be added by the DON or designee to the residents care plan to include appropriate interventions and precautions for staff and visitors.</p> <p>Resident 2 will be evaluated by the RD. Dietary will offer food she likes to increase intake. Staff will encourage her to have appropriate intake with meals. CP will be updated by the DON or designee to reflect this and intake will be recorded by dietary staff. Weight will be monitored weekly by the DON or designee. Findings will be reported to the QA committee monthly and then quarterly per QA findings.</p> <p>Resident 9's care plan will be developed by the Activities director, it will be</p>		

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F 280	Continued From page 8  Interview on 9/17/14 at 8:00 a.m. with the director of nursing (DON) confirmed resident 1 had not currently been receiving PT services. She had been receiving RT services. She was not aware of the calendar and clock sizes.  2. Random observations from 9/15/14 at 1:45 p.m. through 9/17/14 at 10:45 a.m. revealed resident 5 resting in bed, wheeling herself throughout the building, or in the dining room drinking coffee or eating her meals. During that time she had not participated in any activities.  Review of resident 5's medical record revealed a flow sheet on which staff had recorded her weights. That flow sheet revealed she had been at or below 97 pounds (lb.) since 3/14/13. Her current weight had been 90.5 lb on 9/3/14.  Review of resident 5's care plan revealed: *A revised 12/6/13 focus area of "The resident is involved in few group activities. Resident is very homesick which may be a contributing factor." *The goal had been "The resident will attend/participate in activities of choice 2-3 times weekly by next review date." *Interventions were: -"All staff to converse with resident while providing care." -"Encourage ongoing family involvement." -"Ensure that the activities the resident is attending are: Compatible with physical and mental capabilities; Compatible with known interest and preferences; Compatible with individual needs and abilities; and Age appropriate." -"Provide with activity calendar." -"Thank resident for attendance at activity	F 280	individualized, comprehensive and up to date. It will include resident's current interests and preferences.  The interdisciplinary team and nursing staff will be educated on the care plan process as well as diagnosis of VRE and precautions needed.  The Activities director will review all active resident charts to assure all residents have individualized, comprehensive and up to date activities care plans.  The Activities director and DON will identify other residents who would benefit from 1:1 activities and a care plan will be developed.  The DON or designee will review 25 % of active resident files on a monthly basis to assure the activities care plans are individualized, comprehensive and up to date. Findings will be reported by the DON monthly for the first quarter and then quarterly per QA findings.	

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F 280	<p>Continued From page 9 function."</p> <p>*The care plan did not list the resident's preferences or interests for this focus area. -The resident was unable to be interviewed for preferences or interests due to 6/8/14 BIMS (mental examination) had been 3, which indicated severe impairment in thought processes.</p> <p>*A revised 4/1/14 focus area of "Resident is at risk for weight loss: The resident has potential for oral/dental health problems... Resident at risk for weight loss due to liberalized mechanical diet with protein shakes at every meal and need for set up help with meals." *One of the goals had been "Resident will maintain current weight of 97# (lb.) without weight loss by next care plan review." -There had not been any new interventions placed since the weight went below 97 lb.</p> <p>Interview on 9/17/14 at 8:00 a.m. with the DON confirmed resident 5 had been flagged for a weight loss and interventions had been put in place. The registered dietician had been involved with her weight loss management.</p> <p>Interview on 9/17/14 at 8:00 a.m. with the director of nursing (DON) confirmed resident 5's care plans should reveal the current resident conditions and care needed.</p> <p>Review of the provider's revised August 2002 Care Plan policy revealed care plans "will be modified to reflect the care currently required/provided for resident."</p> <p>Surveyor: 32333 3. Review of resident 6's complete medical record revealed:</p>	F 280		

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F 280	<p>Continued From page 10</p> <p>*She had been admitted on 9/1/08.</p> <p>*She had the following diagnoses, but not limited to:</p> <ul style="list-style-type: none"> <li>-Dementia (confused mental thinking).</li> <li>-Cerebralvascular accident (stroke).</li> <li>-Diabetes.</li> <li>-Decubitus ulcer (pressure ulcer).</li> <li>-Blindness of the left eye.</li> </ul> <p>Review of resident 6's current undated care plan revealed no activities had been care planned.</p> <p>Interview on 9/17/14 at 9:30 a.m. with the activity director revealed resident 6 should have had activities on her care plan.</p> <p>Interview on 9/17/14 at 10:35 a.m. with the director of nursing revealed resident 6 should have had activities on her care plan, but it had been missed.</p> <p>4. Review of resident 8's complete medical record revealed:</p> <p>*He had been originally admitted on 12/12/08.</p> <p>*He had a laboratory report on 8/25/14 that confirmed he had Vancomycin resistant entreococcus (VRE) (A bacterial infection resistant to the antibiotic Vancomycin).</p> <p>Review of resident 8's 8/25/14 nursing notes revealed the resident was positive for VRE, and he was currently on Rocephin (antibiotic medication). They would notify the primary care provider and educate staff on the precautions needed with that infection.</p> <p>Review of resident 8's current undated care plan revealed there had been nothing care planned regarding the resident's infection with VRE. There</p>	F 280		

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F 280	<p>Continued From page 11</p> <p>was no mention about any precautions that should have been taken by staff or visitors.</p> <p>Interview on 9/17/14 at 10:35 a.m. with the DON revealed she would have expected resident 8's care plan to have been updated to include his infection of VRE. The care plan should have had interventions and goals related to that infection.</p> <p>Surveyor: 32573</p> <p>5. Review of resident 2's care plan revealed: *A goal dated 8/20/13 revised on 4/10/14 of maintaining adequate nutritional status by: -Maintaining weight within five pounds of eighty-five pounds. -Consuming at least fifty to seventy-five percent of meals daily.</p> <p>Review of her nutrition progress notes dated 7/11/14 revealed her meal intake had been forty percent. She had been under her goal weight the following dates: *4/30/14- 78.5 lbs. *5/31/14- 77.5 lbs. *6/28/14- 78 lbs.</p> <p>Review of her meal intake records from 6/1/14 to 8/31/14 revealed she had not met her meal consumption goal of eating fifty to seventy-five percent of the meals forty-nine times in June, thirty times in July, and thirty-nine times in August.</p> <p>6. Review of resident 9's activity evaluation dated 6/17/14 revealed there had been many items checked as current interests on the evaluation such as sports, computer, trips, being outdoors, conversing, and news.</p>	F 280		

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F 281 SS=D	<p>Review of resident 9's care plan revealed individualized focus areas, goals, and interventions related to activities had not been included.</p> <p>Interview on 9/17/14 at 9:10 a.m. with resident 9 revealed he was younger than most of the residents in the facility. His physical disabilities had gotten worse. He had been pretty self sufficient when he was still working but needed more care now. He believed the facility was still "figuring stuff out for him" to do.</p> <p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, interview, policy review, and manufacturer's instructions review, the provider failed to ensure: *Levemir insulin (medication to lower blood sugar) was administered via a FlexPen (dial-a-dose insulin pen) according to manufacturer's instructions for one of one random resident (11) using a FlexPen. *Physician's orders had been followed for one of one sampled resident (3) with an order for strict review of his intake and output (I&amp;O) (amount of fluids he had consumed and amount he had urinated). Findings include:</p>	F 281		

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F 281	<p>Continued From page 13</p> <p>1. Observation on 9/16/14 at 7:30 a.m. revealed licensed practical nurse (LPN) B had prepared to administer ten units of Levemir insulin to resident 11 via a FlexPen. She dialed the dose selector on the pen to reflect ten units of insulin. She then administered the insulin to the resident in her abdomen. She immediately removed the FlexPen needle from the resident's skin. Interview with LPN B at that time revealed that was her usual practice, although she did not work frequently with FlexPens.</p> <p>Interview on 9/17/14 at 7:20 a.m. with the director of nursing (DON) revealed the provider did not have a policy on FlexPen usage. She stated the provider felt FlexPens should only be used by residents who were able to self-administer their own medications. She confirmed resident 11 was not capable of giving herself her insulin. She stated they were going to clarify with the physician as to whether or not they could change her insulin to a form received in a vial.</p> <p>Review of the Levemir FlexPen's manufacturer's instructions revealed:            **"Before each injection, small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure you take [administer] the right dose of insulin:            -Turn the dose selector to 2 units.            -Hold the Levemir FlexPen with the needle pointing up.            -Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge.            -While you keep the needle pointing upwards, press the push-button all the way in.            -The dose selector returns to zero.            -A drop of insulin should appear at the needle tip."</p>	F 281	<p>F281 Completion Date 11/06/2014</p> <p>Resident 11's order was changed on 10/14/2014 to discontinue flex pen and use multi dose vial of insulin. Review all other residents currently receiving insulin to assure no flex pens in use and appropriate practice with insulin administration.</p> <p>A notebook will be created for all new orders to be placed in so nursing staff can review this when they start their shift to assure all appropriate information is passed on regarding new medication and treatment orders to assure that accurate and consistent care is given to all residents.</p> <p>All nursing staff will be educated on appropriate administration of meds and use of this new communication tool for new orders to assure continuity of care.</p> <p>The DON or designee will randomly select 4 charts a month to assure staff are providing accurate and consistent care to residents and that nursing is following physician's orders. Findings will be reported by the DON to the QA committee monthly for the first quarter and then quarterly per QA findings.</p>	11/06/14	

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F 281	<p>Continued From page 14</p> <p>***Inject the dose by pressing the push button all the way in.</p> <p>*Keep the needle in the skin for at least six seconds. Keep the push-button pressed all the way in until the the needle has been pulled out from the skin. This will make sure that the full dose has been given."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, MO., 2005, pp. 879-881 revealed: *If a nurse does not administer injections correctly negative outcomes could result. *Insulin should be given in a specific dose as ordered by the physician.</p> <p>2. Review of resident 3's 8/28/14 nurses notes revealed he had been sent to the hospital for evaluation of bloody urine and clots from his catheter. He had returned from the hospital with a physician's orders for his intake and output to have been measured every four hours for twenty-four hours. Those orders stated "strict I&amp;O" and were issued at 4 p.m.</p> <p>Review of resident 3's medical record revealed a sheet had been created to record his I&amp;O every four hours for twenty four hours. Output had been recorded on 8/28/14 at 4:00 p.m., 8:00 p.m., 12:00 midnight, and 4:00 a.m. No output had been recorded after that and it should have been measured until 4:00 p.m. on 8/29/14. Intake had not been documented on that form.</p> <p>Interview on 9/17/14 at 7:30 a.m. with the DON revealed intake would have been recorded at meal times only. She confirmed there had not been any recording of any liquids resident 3 might have consumed in his room. She confirmed the</p>	F 281	first quarter and then quarterly per the QA committee findings.	

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F 281	Continued From page 15 above physician's orders had not been followed.  Review of the provider's revised October 2002 Physician's Orders policy revealed: *The purpose was to provide accurate and consistent care to each resident. *A system was to be in place to ensure transmission of physician's orders to all professionals.  Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, MO., 2005, p. 419, revealed: *The physician was responsible for directing medical treatment. *Nurses were obligated to follow physician's orders unless they believed the orders were in error or would harm clients.	F 281		
F 282 SS=D	<b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b>  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on record review, observation, and interview, the provider failed to ensure care plans were followed for one of nine sampled residents (2) care. Findings include:  1. Review of the provider's current resident list revealed resident 2 had been noted as having weight loss.	F 282		

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F 282	<p>Continued From page 16</p> <p>A 6/27/14 nurses note revealed she had a significant weight loss of 15 percent (%) of total body weight in 180 days or 6 months. She had been moved to the feeding assisted table, so staff could help her stay awake and encourage her during meals.</p> <p>Review of resident 2's nutrition progress notes signed by the registered dietician (RD) on 7/11/14 revealed the following weights: *1/18/14 - 93 pounds (lb). *2/26/14 - 87 lb. *3/26/14 - 80 lb. *4/30/14 - 78.5 lb. *5/31/14 - 77.5 lb. *6/28/14 -78 lb.</p> <p>A recommendation or intervention from the RD had been "Will continue to offer current diet and encouragement."</p> <p>Review of resident 2's current care plan revealed: *A focus area of activities of daily living self-care performance deficit (trouble taking care of self). *An intervention initiated 8/14/13 had stated she required set-up help and supervision with eating. *A focus area of nutritional problems, and she had been at risk for weight loss. *An intervention dated 8/20/13 of monitoring for signs of dysphagia (trouble swallowing), refusing to eat, and appearing concerned during meals.</p> <p>Observation on 9/15/14 at 5:30 p.m. during the supper meal revealed resident 2 had entered the dining room in her wheelchair. She had not seated herself at the assisted table. She sat at another table and was served at approximately 5:40 p.m. She ate by herself for about ten minutes, and then left the dining room. No staff</p>	F 282	<p>F282 Completion Date: 11/06/2014</p> <p>Resident 2 will continue to be evaluated by the RD monthly until weight returns to baseline. Dietary will offer food she likes to increase intake. She will sit at the feeder table where staff can provide set up assist, supervision, and encourage her to have appropriate intake with meals. Resident 2 will receive snacks of her liking between meals. CP will be updated by the DON or designee. Findings will be reported to the QA committee monthly for the first quarter and then quarterly per QA findings.</p> <p>The DON will communicate directly with the RD regarding appropriate intervention suggestions and effectiveness of current interventions.</p> <p>All active residents will be reviewed to assess for wt loss by the DON or designee. Care plans will be reviewed to assure they are individualized, comprehensive and up to date. DON will assure that the interventions are being carried out for all residents with wt loss. Findings will be reported by the DON to the QA committee monthly for the first quarter and then quarterly per QA findings.</p>	11/06/14

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F 282	Continued From page 17 had supervised or encouraged her. She had eaten an estimated less than 40% of her meal.  Observation on 9/16/14 at 7:30 a.m. of the breakfast meal revealed resident 2 entered the dining room at approximately 7:50 a.m. She did not sit at the assisted table and ate by herself without supervision or encouragement. She left the dining room at 8:10 a.m. She had eaten an estimated less than 30% of her meal.  Interview on 9/16/14 at 10:30 a.m. with the director of nursing (DON) revealed she would have expected resident 2 to be at the assisted table for cues if her care plan called for meal supervision. It should have been followed especially since her intake had been low, and she had weight loss.	F 282			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, record review, interview, and policy review, the provider failed to ensure	F 315			

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F 315	<p>Continued From page 18</p> <p>documentation by the medical provider of the reason for the continued use of a Foley catheter (tube to drain the bladder) for one of two sampled residents (3). Findings include:</p> <p>1. Observation on 9/15/14 at 2:05 p.m. of resident 3 revealed he had an indwelling Foley catheter (a tube to drain urine from the bladder). Interview on that same day at 2:15 p.m. with licensed practical nurse L regarding resident 3 revealed he had a history of multiple and frequent urinary tract infections during the time the catheter had been in place.</p> <p>Review of resident 3's updated 11/13/13 continuing problem list revealed an active problem of benign prostatic hypertrophy (BPH) [swelling of the prostate limiting urine flow] with urinary obstruction (blockage) and retention (unable to completely empty the bladder).</p> <p>Review of his 11/13/13 transfer orders from the hospital revealed an attempt to stop the use of the Foley catheter was to have been done according to the provider's protocol. An attempt had been made to discontinue the catheter at that time but was unsuccessful. The catheter was re-inserted on 11/14/14. No order to re-insert that Foley catheter was found. No further documentation of an attempt to discontinue the Foley catheter was found in the nurse's notes.</p> <p>Review of resident 3's revised 7/15/14 care plan revealed on 12/13/13 the resident's Foley catheter remained in place at that time. A 1/20/14 care plan entry revealed the Foley catheter would continue until further notice.</p> <p>Review of resident 3's physician's progress notes</p>	F 315	<p>F315 Completion Date: 11/06/2014</p> <p>On 10/06/2014 an order for Foley catheter was obtained with necessitating diagnosis for continuing Foley catheter for Resident 3. On physician recertification physician orders dated 4/16/2014, 6/6/2014, 8/18/2014 and 9/30/2014, it is noted under diagnosis that patient has BPH with urinary obstruction. DON or designee will review residents TAR and care plan to assure appropriate interventions are in place to decrease chances of CAUTI.</p> <p>The DON will obtain an updated progress note from the provider to include the necessitating diagnosis for continuing Foley catheter on Resident 3.</p> <p>The DON or designee will write an update in the nurses notes identifying the need for continued catheterization of resident.</p> <p>Nursing staff will be educated on this process.</p> <p>The DON or designee will review all active residents with Foley catheters in place monthly to assure appropriate diagnosis and interventions in place for</p>	11/06/14	

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F 315	Continued From page 19 from 11/13/13 through 8/18/14 revealed there was no mention of the need or reason for the continuation of the Foley catheter. The BPH and urinary obstruction/retention was not mentioned in those notes.  Interview on 9/16/14 at 1:00 p.m. and at 2:00 p.m. with the Minimum Data Set coordinator revealed she was sure the diagnosis of BPH and urinary obstruction/retention remained. She confirmed no documentation could be found by the physician for the reason and justification for continuing on with the Foley catheter.  Review of the provider's revised September 2007 Indwelling Catheter Management policy revealed: *A resident should not have been catheterized unless their condition demonstrated that it was necessary. *An indwelling Foley catheter for continuing use not medically justified would be discontinued as soon as clinically warranted per physician's order. *For residents with an indwelling Foley catheter information to support its use must have been documented in the nurse's notes.	F 315	continued use. This will be done monthly for the first quarter and then quarterly per QA committee findings. The DON will report findings to the QA committee. <i>*these JAS/DCM/MP</i>		
F 323 SS=E	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	F 323			

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F 323	<p>Continued From page 20 .</p> <p>by: Surveyor: 32572</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure:</p> <p>*Safety assessments and/or care planning for the use of grab bars, positioning assistive devices, or side rails had been completed for three of four sampled residents with grab bars or side rails on their beds (1, 4, and 9).</p> <p>*Chemicals had been properly labeled in two of two whirlpool bath areas and two of two housekeeping carts.</p> <p>*Chemicals had been properly stored inaccessible to residents in two of two housekeeping carts.</p> <p>*Treatment carts had been secured when not in attendance in one of two hallways (A). Findings include:</p> <p>1. Random observations from 9/15/14 at 1:45 p.m. through 9/17/14 at 11:00 a.m. revealed resident 1 had one grab bar on the top right side of her bed. The call light and overhead light cords had been wrapped around that bar.</p> <p>Interview on 9/15/14 at 4:15 p.m. with resident 1 revealed she did not use the grab bar when in bed or when attempting to enter or exit the bed.</p> <p>Review of resident 1's medical record revealed: *No safety assessment had been completed for the use of the grab bar. *The care plan did not indicate the use or need for the grab bar.</p> <p>Surveyor 32573</p> <p>2. Random observations from 9/15/14 at 1:45 p.m. through 9/17/14 at 11:00 a.m. revealed resident 9 had one grab bar on the top right side</p>	F 323	<p>F 323 Completion Date: 11/06/2014</p> <p>The grab bar will be removed from Resident 1's bed as she indicated she does not use it. A safety assessment will be completed on resident 4 and 9 regarding use of grab bars by the MDS coordinator. Care plan will be updated for resident 4 and 9 to indicate use and need of grab rail by the MDS coordinator.</p> <p>All active residents will be reviewed by DON or designee for use of positioning devices and side rails to assure these residents have a safety assessment completed, restraint assessment as needed and care plan reflects current plan of care. These assessments will be done Quarterly with the interdisciplinary care team.</p> <p>The policy for side rails was reviewed on 10/14/2014 by the DON and updated to include appropriate grab bar assessment/usage.</p> <p>The DON or designee will QA this process monthly for three months and quarterly per QA findings. The DON will report these findings to the QA committee.</p>	11/6/14	

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F 323	<p>Continued From page 21 of his bed.</p> <p>Review of resident 9's care plan revealed that a grab bar was to be used for safety while staff provided care. There had been no assessment done to determine that the grab bar was not a restraint.</p> <p>Surveyor 23059 3. Random observation beginning on 9/15/14 at 2:15 p.m. through 9/17/14 at 11:00 a.m. revealed resident 4 had a grab bar on the left side of her bed.</p> <p>Review of resident 4's medical record revealed : *No safety assessment had been completed for the use of the grab bar. *The care plan did not indicate the use or need for the grab bar.</p> <p>Surveyor 32572 4. Interview on 9/16/14 at 10:35 a.m. with the administrator and the Minimum Data Set (MDS) nurse confirmed the provider did not complete safety assessments for the use of grab bars, positioning assistive devices, or side rails. The provider did complete restraint assessments for the use of full side rails and other types of devices. The provider had not care planned the use of the positioning devices by the residents.</p> <p>Review of the provider's revised August 2002 Care Plan policy revealed care plans "Will be modified to reflect the care currently required/provided for resident."</p> <p>A policy for side rail and grab bar usage had been requested on 9/16/14 at 5:15 p.m. It had not been received by 9/17/14 at 2:15 p.m. when the survey</p>	F 323	<p>The interdisciplinary team, nursing staff, and providers will receive education on this process on by 10/16/2014.</p> <p>The unlabeled chemicals in the bath houses used for the whirlpool tub were labeled by housekeeping supervisor. All chemicals on the housekeeping carts for A and B hall were labeled by housekeeping supervisor.</p> <p>Housekeeping and Nursing staff will be educated on the necessity of chemicals being labeled and stored appropriately, to include carts not being left unattended or out of sight.</p> <p>The Hazardous and Toxic Substances policy will be updated to indicate the updated date and to indicate all substances will be labeled prior to use and secure.</p> <p>The Housekeeping supervisor will QA this process twice weekly for the first 3 months and then quarterly as per QA findings. The Housekeeping supervisor will report these results to QA.</p> <p>The nursing staff will be educated on the importance of keeping the treatment cart secured when not in sight. The DON or designee will QA this</p>		

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F 323	<p>Continued From page 22 ended.</p> <p>5. Observation on 9/15/14 at 2:07 p.m. and one on 9/16/14 at 9:30 a.m. revealed unlabeled and unsecured chemicals were used to disinfect the whirlpool tub. Refer to F441, finding 1.</p> <p>6. Observation on 9/15/14 at 1:45 p.m. revealed housekeeping carts on hallways A and B had unlabeled chemicals stored on them.</p> <p>Surveyor: 32573 Observation on 9/15/14 at 2:15 p.m. revealed the housekeeping cart had been left unattended outside the social services room in hallway A. Bottles of unlabeled chemicals had been left unsecured. The housekeeper was cleaning in the social services room and the cart had been out of her sight.</p> <p>Observation on 9/16/14 at 10:20 a.m. revealed the housekeeping cart had been left unattended outside a room in the hallway A. A bucket of cleaning solution had been left uncovered on the cart. There were bottles of chemicals left unsecured. The housekeeper was in a resident's room cleaning and the cart had been out of her sight.</p> <p>Surveyor 32572 Those carts with unsecured chemicals were accessible to residents and visitors who were in the hallway during that time. There had been residents and visitors in the hallways at that time.</p> <p>Interview on 9/16/14 at 1:10 p.m. with the housekeeping supervisor confirmed chemicals were to be labeled and secured from residents.</p>	F 323	process monthly for the first three months and then quarterly per QA findings. The DON will report these findings to the QA committee.	
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F 323	Continued From page 23  Review of the provider's undated Hazardous and Toxic Substances policy revealed: *"All hazardous/toxic substances used in our facility will be identified and labeled prior to being used." *There had been no mention the chemicals needed to be secured.  Surveyor: 23059 7. Observation on 9/16/14 from 7:15 a.m. to 7:30 a.m. revealed licensed practical nurse B was doing blood sugar checks on several residents in the A hallway. She obtained the blood sugar testing equipment from the treatment cart. She then entered the residents' rooms and shut the door behind her. She had not locked the treatment cart upon entering the resident's rooms. The treatment cart contained syringes, lancets, and medications. Multiple staff and residents were in the hallway at that time where the treatment cart was located.  Interview on 9/17/14 at 7:20 a.m. with the director of nursing revealed it would have been her expectation the treatment cart should have been locked when not in use.	F 323		
F 364 SS=D	Surveyor: 32573 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364		

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F 364	<p>Continued From page 24</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation and interview, the provider failed to maintain the nutritional value of food for all six residents on a pureed diets during one of two observed meal services. Findings include:</p> <p>1. Observation and interview on 9/15/14 at 4:55 p.m. of cook C while preparing pureed foods for residents for the evening meal service revealed: *He had a pitcher of hot water next to the blender. *He had just finished pureeing the au gratin potatoes. *He stated he had added about half a cup of hot water to the au gratin potatoes. *He put six servings of zucchini in the blender and added hot water. *Then he put his ham into the blender and added hot water. *The pureed ham was water consistency. *He served that ham to the residents that had required a pureed diet.</p> <p>Interview on 9/15/14 at 6:05 p.m. with the administrator revealed she would have expected the ham to have been at a thicker consistency. She would also have expected the cook to use a liquid with a nutritive value to thin pureed foods.</p> <p>Interview on 9/16/14 at 5:30 p.m. with the registered dietician revealed he would have expected something with calories had been added to thin the pureed foods such as milk or broth.</p> <p>A policy had been requested for pureed foods on 9/16/14 at 5:15 p.m., but none was provided by</p>	F 364	<p>F364 Policy for pureed foods will be reviewed and updated by the RD to ensure the nutritive value of foods is maintained for all mechanically altered diets and proper consistency of foods served. DM will educate all dietary staff at inservice on 10/23/14. DM will randomly monitor 3 meals per week to assess appropriate preparation of all mechanically altered diets per policy and report findings monthly to QA Committee for one quarter and then adjust per QA findings.</p>	11/6/14

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F 364	Continued From page 25 the end of the survey on 9/17/14 at 2:15 p.m.  Lisa Eckstein and Katheryn Adams, Pocket Resource for Nutritional Assessment, 2013 Ed., Chicago, IL., 2013, pp. 103 and 106, revealed dysphagia (problems with swallowing) can result in serious health consequences as it can interfere with adequate nutrition and hydration. To minimize swallowing problems, and maximize nutrition, hydration, and quality of life for the resident, dietary modifications involve changes in food and/or liquid texture to help compensate for loss of function, to maintain appropriate nutritional and hydration status, and to reduce the risk of aspiration. Those might include temperature changes and order of food/liquid presentation changes such as moistening and providing a cohesive bolus (to hold an amount together) by adding gravy or sauce.	F 364		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  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  This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, the provider failed to ensure appropriate handwashing, glove	F 371		

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F 371	Continued From page 26 use, and handling of ready-to-eat food items had been done by one of two observed cooks (C) while preparing one of one meal. Findings include:  1. Observation on 9/15/14 at 4:55 p.m. of cook C while preparing the evening meal revealed: *He had performed multiple tasks with gloved hands that included: -Pureeing foods. -Handled kitchen equipment such as blenders and pans. -Formed hamburger patties. -Wiped countertops. -Touched ready-to-eat food items (hamburger buns and sliced bread) with his soiled gloves. *He had performed many of the above listed tasks with the same gloves on. *He had changed his gloves several times, but had not washed his hands between glove changes.  Interview with the administrator on 9/16/14 at 4:05 p.m. revealed she would have expected cook C: *To have washed his hands before putting on gloves and after glove removal. *When handling ready-to-eat foods he should have: -Washed his hands and put on clean gloves. -Performed one task with those gloves. -Removed those gloves. -Washed his hands. -Used utensils such as tongs.	F 371	F371 Inservice education for dietary personnel will be provided by facility's Infection Control Nurse on October 23, 2014. Topics covered will include appropriate hand washing, glove use, and handling of ready-to-eat food items. Dietary Manager or IC nurse will randomly observe for sanitary practice at 3 meals per week and re-enforce education as needed on a 1:1 basis with dietary staff. Dietary Manager will report results to Quality Assurance Committee quarterly and adjust as needed per QA results and Committee recommendations.  <i>*including cook C</i> <i>JHSDDDHMF</i>	11/6/14
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a	F 441		

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F 441	Continued From page 27 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. (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.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, record review,	F 441	F 441 Completion Date: 11/06/2014 <i>*including CNA F &amp; G</i> All active C.N.A.'s and new hires will complete a whirlpool disinfection competency. The DON or Infection Control Nurse, will assure this is done.  This process will be QA'd by the DON or Infection Control Nurse twice weekly to assure the correct practice is used. Findings will be reported monthly for the first three months and then quarterly as per QA findings. The DON will report to the QA committee. <i>*including MAP D</i> All nurses and med aides will be educated on the appropriate and sanitary administration of medications by the DON or Infection Control Nurse. This process will be QA'd three times a week for the first month and then quarterly per the QA findings. The DON will report to the QA committee. <i>*including LPN B</i> All staff who do glucometer checks will receive education and complete a competency on this process by the DON or Infection Control Nurse. This process will be QA'd twice weekly for the first three months and then quarterly per QA findings by the DON or designee. The DON will report findings to the QA committee.	11/06/14 JASDDCHIME

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F 441	<p>Continued From page 28</p> <p>and policy review, the provider failed to ensure: *Proper disinfection of the whirlpool tub by two of two certified nursing assistants (CNA) (F and G) during two of two observations in two of two whirlpools (A and B hallways). *Proper disinfection of the multiple resident use glucometer (blood glucose [sugar] tracking device) for three of three observed residents (6, 11, and 13) during one of one observations by one of one licensed practical nurse (LPN) (B). *Medications had been administered in a sanitary manner during one of two medication observation by one of two unlicensed assistive personnel (UAP) (D). *A dressing had been changed in a sanitary manner during one of two observed resident 6's dressing changes by one of one observed LPN (B).</p> <p>Findings include:</p> <p>1. Observation on 9/15/14 at 2:07 p.m. in hallway B revealed CNA F had sprayed the interior surfaces of the tub with an unlabeled bottle. She then filled the tub with water and scrubbed the surfaces with a brush. She let the water remain in the tub with the air jets running for ten minutes. She drained the tub and rinsed the surfaces with clear water. She then turned on the "disinfect the air jets button" on the right side of the tub and let it run for one minute. Then she turned on the "rinse the air jet button" and let it run for one minute. The tub was dried with a towel. On the wall beside the left side of the tub the provider's tub disinfection policy had been posted.</p> <p>Interview at that time with CNA F confirmed the above had been the process she had used all the time. The unlabeled bottled she had used had been tub disinfectant. She provided a gallon</p>	F 441	<p><i>x including LPN B JPK/DDH/ME</i></p> <p>All nursing staff will be educated on sanitary dressing changes. The policy will be updated and reviewed with nursing staff by the DON or Infection Control Nurse.</p> <p>The DON or designee will QA one dressing change a week for the first three months and then quarterly per QA findings. The DON will report findings to the QA committee.</p>	

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F 441	<p>Continued From page 29</p> <p>bottle of Penner tub disinfectant that the smaller bottle had been filled from.</p> <p>Observation on 9/16/14 at 9:30 a.m. in hallway A revealed CNA E had performed the same as above tub procedure exactly as CNA F had.</p> <p>Interview at the above time with CNA E confirmed the above had been the process she had used all the time. She confirmed the unlabeled bottle she had used had been tub disinfectant.</p> <p>Interview on 9/17/14 at 8:00 a.m. with the director of nursing (DON) confirmed she would have expected the tub disinfectant to have remained wet on the surfaces for ten minutes. She would have expected the whirlpool policy disinfection to have been followed.</p> <p>Review of the provider's July 2013 Whirlpool bath - Disinfectant policy revealed:          **Press and hold the Disinfect Button located on the right side of the tub. As the button is held down, the properly mixed cleaning solution is running through the air injection system and out all the air jets. Release the button after you see solution coming out of all the air jets and you have one to 1 to 1 1/2 gallons of disinfectant solution in the foot well of the tub."          **Thoroughly scrub all interior surfaces of the tub with the solution that remains in the foot well of the tub. Let disinfectant stay on surface for 10 minutes."          **Rinse the tub's interior surfaces thoroughly with the shower sprayer."          **Press and hold the Rinse button located on the left side of the control panel until clear water runs from all the air jets. Then release the Rinse button."</p>	F 441		

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F 441	<p>Continued From page 30</p> <p>**Finish rinsing the interior surfaces of the tub with the shower sprayer."</p> <p>Surveyor: 23059</p> <p>2. Observation on 9/15/14 at 5:50 p.m. revealed UAP D was punching pills out of a blister pack to give to resident 14. One of those pills landed on top of the medication administration record instead of in the medication cup. UAP D picked up that pill with her bare hands and placed it back in the medication cup to give to resident 14.</p> <p>Interview on 9/17/14 at 7:20 a.m. with the DON revealed any dropped medication should have been discarded. UAP D should not have given that medication to resident 14.</p> <p>3. Observation on 9/16/14 from 7:15 a.m. to 7:30 a.m. revealed LPN B did blood sugar checks on residents 6, 11, and 13 with the same glucometer. After each time she used the glucometer she cleaned it with an alcohol wipe for seven seconds. She stated that was her usual procedure.</p> <p>Review of the provider's July 2012 Glucometer Cleaning policy revealed: *Glucometers for use on more than one resident would be cleaned after each use. *The glucometer was to have been cleaned with a disposable Clorox germicidal wipe. *Alcohol wipes or alcohol were not to have been used.</p> <p>Review of the glucometer's undated manufacturer's instructions revealed: *Alcohol could be used to clean the glucometer. *In order to disinfect the glucometer between residents a 10% (percent) bleach solution should</p>	F 441		

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F 441	<p>Continued From page 31 have been used.</p> <p>During the above glucometer testings LPN B put on gloves twice without washing her hands prior using those gloves.</p> <p>Interview on 9/17/14 at 7:20 a.m. with the DON revealed they had used alcohol to clean the glucometer between residents. She stated she was not aware the alcohol would not disinfect the glucometer from potential spread of germs from resident to resident. She also stated it would have been her expectation hands would have been washed before using gloves.</p> <p>4. Observation on 9/16/14 at 7:20 a.m. revealed LPN B put on gloves prior to administering insulin to resident 11. She did not wash her hands prior to putting on those gloves. After giving the resident her insulin injection she removed her soiled gloves. She did not wash her hands after removing those gloves.</p> <p>Interview on 9/17/14 at 7:20 a.m. with the DON revealed hands should have been washed before and after anytime gloves were used.</p> <p>Review of the provider's revised July 2008 Handwashing and Use of Personal Protective Equipment revealed hands should have been washed after gloves had been removed. That policy did not mention the need to wash hands prior to putting on gloves.</p> <p>Surveyor: 32333</p> <p>5. Observation on 9/16/14 at 10:45 a.m. of LPN B while she had been gathering supplies to perform a dressing change on resident 6 revealed she: *Pushed her treatment cart outside of the</p>	F 441			

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F 441	Continued From page 32 resident's room door. *Opened and reviewed her treatment administration record (TAR) book that was on top of the treatment cart. *Gathered her supplies including gauze, gloves, and betadine (wound treatment) from her cart. *Put her supplies on top of her opened TAR. *Had not put down a barrier to set her clean supplies on. *Put her scissors in her scrub top pocket. *Entered the resident's room and put her supplies on top of the resident's bedside table. -The resident's bedside table had multiple personal items on it. *Had not put down a barrier to set her clean supplies on before performing her dressing change.  Interview on 9/17/14 at 10:35 a.m. with the DON revealed she would have expected a barrier to have been placed and dressing change supplies not to have been possibly cross-contaminated before performing the dressing change.  Review of the provider's 11/01/06 Wound Assessment policy "Follow all universal precautions".	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	F 514			

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F 514	<p>Continued From page 33</p> <p>information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333</p> <p>Surveyor: 32572</p> <p>Surveyor: 32573</p> <p>Surveyor: 23059</p> <p>Based on record review, interview, and policy review, the provider failed to ensure complete and accurate documentation was maintained on: *Medication administration records (MAR) for six of nine sampled residents (1, 3, 4, 5, 6, and 9). *Treatment administration records (TAR) for two of nine sampled residents (6 and 9). *Diabetic sheets for one of nine sampled residents (6). Findings include:</p> <p>1a. Review of resident 3's June through September 2014 MARs revealed the following medications had not been documented as given: *June: -Carafate (for stomach ulcers) three times. -Glimeperide (for diabetes) one time. -Lisinopril (for blood pressure) two times. -Advair diskus (treats breathing difficulties) one time. -Spirivia inhaler (treats breathing difficulties) one time. -Aspirin one time.</p>	F 514	<p>F 514 Completion Date: 11/06/2014</p> <p>Nursing staff and UAP's will receive education on appropriate and accurate documentation on MAR's, TAR's and diabetic sheets. Staff identified through QA process of not documenting accurately will receive further education as needed.</p> <p>The DON or designee will review MAR's, TAR's and diabetic sheets in entirety on a weekly basis to assure documentation is maintained and accurate. This will be done weekly for the first three months and then quarterly. [REDACTED] will be reported to the QA committee by the DON.</p> <p>* including residents 1, 3, 4, 5, 6 and 9 along with other randomly selected resident, [REDACTED]</p> <p>* including residents 6 and 9 along with other randomly selected residents, [REDACTED]</p> <p>* including resident 6 and other randomly selected residents, [REDACTED]</p> <p>* These findings [REDACTED]</p>	11/6/14

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F 514	Continued From page 34 -Clopidogrel (reduces clotting) one time. -Docusate sodium (stool softner) one time. -Finasteride (treats swelling of the prostate) one time. -Fludrocortisone acetate (steroid) one time. -Dulcolax (laxative) two times. -Vitamin B12 one time. -Amlodipine (for blood pressure) one time. -Metoprolol (for blood pressure) one time. -Senokot (stool softener) three times. -Vitamin D one time. -Fluticasone nasal spray (to improve breathing) two times. -Novolog insulin two times.  *July: -Carafate two times. -Spirivia inhaler one time. -Dulcolax one time. -Senokot one time. -Fluticasone nasal spray three times. -Novolog insulin seven times.  *August: -Carafate six times. -Glimerperide three times. -Lisinopril three times. -Advair diskus two times. -Spirivia inhaler four times. -Aspirin three times. -Clopidogrel three times. -Docusate sodium two times. -Finasteride three times. -Fludrocortisone acetate three times. -Dulcolax nine times. -Vitamin B12 three times. -Amlodipine three times. -Metoprolol three times. -Senokot one time.	F 514		

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F 514	<p>Continued From page 35</p> <ul style="list-style-type: none"> <li>-Vitamin D three times.</li> <li>-Fluticasone nasal spray five times.</li> <li>-Ranitidine (acid reducer) six times.</li> </ul> <p>*September:</p> <ul style="list-style-type: none"> <li>-Carafate one time.</li> <li>-Advair diskus one time.</li> <li>-Clopidogrel one time.</li> <li>-Senokot two times.</li> </ul> <p>b. Review of resident 4's July 2014 MAR revealed the following medications had not been documented as given:</p> <ul style="list-style-type: none"> <li>*Lasix (diuretic) three times.</li> <li>*Multivitamins three times.</li> <li>*Namenda (for dementia) three times.</li> <li>*Aricept (for dementia) three times.</li> </ul> <p>Surveyor 32572</p> <p>c. Review of resident 1's July through August 2014 MAR revealed the following medication had not been documented as given:</p> <p>*July:</p> <ul style="list-style-type: none"> <li>-Zoloft (an antidepressant) two times.</li> </ul> <p>*August:</p> <ul style="list-style-type: none"> <li>-Every medication had not been signed on one day, the 15th.</li> <li>-Buspar (for anxiety) two times.</li> <li>-Risperidone (antipsychotic) two times.</li> <li>-Colace (stool softener) two times.</li> <li>-Sodium bicarb (electrolyte) two times.</li> <li>-Potassium chloride (electrolyte) one time.</li> <li>-Zoloft one time.</li> <li>-Mycophenolate mofetil (lowers the body's ability to fight infections) once.</li> <li>-Prednisone once.</li> <li>-Multivitamin once.</li> <li>-Ferrous Sulfate (iron supplement) once.</li> </ul>	F 514		

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F 514	<p>Continued From page 36</p> <ul style="list-style-type: none"> <li>-Furosemide (water pill) once.</li> <li>-Clopidogrel bisulfate (cholesterol) once.</li> <li>-Aricept (memory) three times.</li> </ul> <p>*September from the 1through 14: -Ofloxacin (antibiotic) eye drop twice.</p> <p>Review of resident 1's nurses notes did not indicate why any of the above medications had not been given.</p> <p>d. Review of resident 5's July through August 2014 MAR revealed the following had not been documented as given: *July: -Lasix (water pill) two times. -Omeprazole (acid indigestion) one time. -Metoprolol (high blood pressure) one time. -Folic acid (vitamin) two times. -Tylenol three times. -Multivitamin one time. -Calcium and Cholecalciferol (vitamin) one time. -Ferrous sulfate (iron supplement) one time.</p> <p>*August: -Lasix five times. -Metoprolol one time. -Tylenol four times. -Ferrous sulfate one time.</p> <p>*September MAR from the 1through 14: -Imdur (used for chest pain) one time. -Folic acid one time. -Tylenol one time.</p> <p>Review of resident 5's nurses notes did not indicate why the any of the above medications had not been given.</p>	F 514		

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F 514	<p>Continued From page 37</p> <p>Surveyor 325733</p> <p>e. Review of resident 9's August 2014 MAR revealed the following had not been documented as given:</p> <p>*August MAR:</p> <ul style="list-style-type: none"> <li>-Chlorhexidine (oral rinse) one time.</li> <li>-Keppra (for seizures) one time.</li> <li>-Alphagan eye drops (allergan) three times.</li> </ul> <p>*Review of resident 9's nurses notes did not indicate why the medications had not been given.</p> <p>Surveyor 32572</p> <p>Review of the provider's revised September 2002 Administration of Medications policy revealed:</p> <ul style="list-style-type: none"> <li>*Omitted medications should have been documented along with reasons for omission.</li> <li>*If the resident refused the medication that should have been documented in the medication record.</li> <li>*The physician should have been notified of omissions and refusals.</li> </ul> <p>Surveyor 32533</p> <p>2a. Review of resident 6's July, August, and September 2014 treatment administration records revealed for the following:</p> <p>*July:</p> <ul style="list-style-type: none"> <li>-An order to check her air mattress, Gel cushion to her wheelchair, and foam boots two times a day. There had been no documentation that had been done in the morning for six times.</li> <li>-An order for wound care in the morning and evening. That had not been documented as completed for six times.</li> <li>-An order to encourage fluids in the morning and evening that had not been documented as completed for eight times.</li> <li>-An order for monitoring how the she swallowed two times a day. That had not been documented as completed six times.</li> </ul>	F 514			

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F 514	<p>Continued From page 38</p> <p>-An order for repositioning every two hours that had not been documented as completed forty-six times.</p> <p>*August:</p> <p>-An order to check her air mattress, Gel cushion to her wheelchair, foam boots two times a day. There had been no documentation that had been done in the morning for three times. There had been no documentation it had been done in the evening one time.</p> <p>-An order for the wound care nurse to evaluate her wounds weekly. That had not been documented as completed four times.</p> <p>-An order to check her air mattress, Gel cushion to her wheelchair, foam boots two times a day. There had been no documentation that had been done in the morning six times.</p> <p>-An 8/26/14 order for wound care two times a day had not been documented as completed three times.</p> <p>-An order monitoring how she swallowed two times a day. That had not been documented as completed three times.</p> <p>-An order to apply lotion to feet nightly that had not been documented as completed once.</p> <p>*9/1/14-9/14/14:</p> <p>-An order to check her air mattress, Gel cushion to her wheelchair, foam boots two times a day. There had been no documentation that had been completed three times.</p> <p>-An order to encourage fluids in the mornings and evenings that had not been documented as completed once.</p> <p>-An order monitoring how she swallowed two times a day. That had not been documented as completed once.</p> <p>-An order for wound care to her left heel two times a day. That had not been documented as</p>	F 514			

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F 514	<p>Continued From page 39 completed five times.</p> <ul style="list-style-type: none"> <li>-An order for wound care to her middle toe on her right foot. That had not been documented as completed five times.</li> <li>-An order monitoring how the she swallowed two times a day. That had not been documented as completed once.</li> <li>-An order for repositioning every two hours that had not been documented as completed thirteen times.</li> </ul> <p>Surveyor 32533 b. Review of resident 9's July and August 2014 TAR revealed the following had not been documented as given:</p> <p>*July:</p> <ul style="list-style-type: none"> <li>-Biotene (dry mouth rinse) 22 times.</li> <li>-Cleansing of the right ear eight times.</li> <li>-The addition of mineral or baby oil to both ears three times.</li> </ul> <p>*August:</p> <ul style="list-style-type: none"> <li>-Biotene 16 times.</li> <li>-Cleansing of the right ear twice from the first through the 18th. It had been documented as healed on the 19th.</li> <li>-The addition of mineral or baby oil to both ears three times.</li> </ul> <p>Review of resident 9's nurses notes did not indicate why the treatments had not been completed.</p> <p>Surveyor 32333 3. Review of resident 6's July, August, and September 2014 Diabetic Sheet revealed: *A 5/23/14 order for 15 units of Lantus insulin at night. That medication had not been documented as given twice in July and once in August.</p>	F 514		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/17/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BENNETT COUNTY HOSPITAL AND NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>102 MAJOR ALLEN POST OFFICE BOX 70 MARTIN, SD 57551</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
F 514	Continued From page 40 *An 8/15/14 Lantus insulin order for 15 units two times a day in the morning and evening. There had been no documentation of the site where the medication had been administered on the morning of 8/18/14, 8/27/14, and 9/14/14.	F 514		

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ORIGINAL

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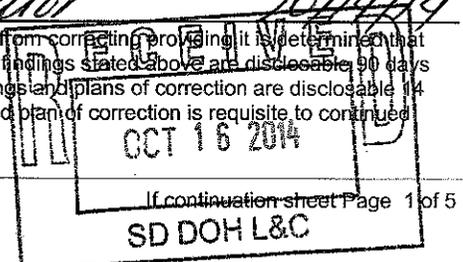
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/17/2014</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/17/14. Bennett County Hospital and Nursing Home was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 9/18/14 upon correction of the deficiencies identified below.</p> <p>Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K011, K052, and K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
K 011 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider</p>	K 011		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Eddel Martin* TITLE *Administrator* (X6) DATE *10/14/14*

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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K 011	Continued From page 1 failed to maintain one of one two hour fire rated common wall separating the nursing home from the hospital that was a non-conforming building. Findings include:  1. Observation at 10:50 a.m. on 9/17/14 revealed a pair of cross-corridor doors in the two hour fire rated wall separating the nursing home from the hospital. Further observation revealed the fire rated latching hardware to those doors was inadequate. Those doors should be provided with two means of latching. Latching was provided from each door leaf into the top of the frame. Door latching was not provided from each door leaf into the floor.  Interview with the maintenance supervisor at the time of observation revealed the latching hardware that latched those leaves into the floor had been removed. He further stated the hardware had been damaged by wheel chairs passing through those doors and had to be removed. He was not aware of the dual latching requirement for those doors.	K 011	<b>K011</b> Door latch mechanisms for door leaf into floor were ordered on 10/01/14 and upon receipt of these parts the Maintenance Supervisor will install. Maintenance Supervisor will check all cross-corridor fire rated doors monthly for proper functioning and report to QA Committee quarterly.	10/6/14
K 033 SS=C	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  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:	K 033		F

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K 033	Continued From page 2 Surveyor: 32334 Based on observation and document review, the provider failed to maintain a protected path of egress from the basement to the exterior of the building. The single basement stairway discharged onto the main level and was not provided with a one hour fire resistive enclosure to the exterior of the building. Findings include:  1. Observation at 1:00 p.m. on 9/17/14 revealed a basement stair enclosure discharged onto the main level corridor system. A continuous one hour enclosure was not provided to the exterior of the building. Review of the previous life safety code survey conducted on 8/25/13 confirmed that finding.	K 033		
K 052 SS=E	The building meets the FSES. Please mark an "F" in the completion date column. NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4  This STANDARD is not met as evidenced by: Surveyor: 32334	K 052		

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K 052	Continued From page 3 Based on record review and interview, the provider failed to ensure the automatic fire alarm system was tested during the months where silent fire drills were conducted. Findings include:  1. Record review at 9:30 a.m. on 9/17/14 of the provider's fire drill reports revealed the provider was conducting fire drills once per month. Further review revealed silent drills were being conducted for the night shift during certain months with no indication the fire alarm system was being tested. Interview with the maintenance supervisor at the time of document review revealed no testing of the fire alarm system was conducted during those months. Only a silent walkthrough of the fire drill was done at night. Silent fire drills were permitted, however a monthly test on the fire alarm system is required.	K 052	<b>K052</b> Maintenance Supervisor will test the automatic fire alarm system one time during any month that silent drills are conducted and document results. Maintenance supervisor will report findings quarterly to QA Committee.	11/10/14
K 062 SS=D	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain the automatic sprinkler system in reliable operating condition in one randomly observed location (sprinkler riser). Findings include:  1. Observation at 11:40 a.m. on 9/17/14 revealed a sprinkler riser in the basement of the nursing	K 062		

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K 062	Continued From page 4 home. Further observation revealed an electrical ground line had been connected to the sprinkler riser. In no case shall the sprinkler piping be used for grounding of electrical services. Interview with the maintenance supervisor at time of observation revealed he was not aware of that requirement.	K 062	<b>K062</b> Maintenance Supervisor contacted local electrical contractor on 10/07/14 regarding the need to disconnect the ground line from the sprinkler riser in the NH basement. Repair is scheduled for the week of 10/13-10/17/14. Maintenance Supervisor will report to Administrator when repair is made and will then check system quarterly to ensure sprinkler piping is not used for any other purposes. Maintenance Supervisor will report findings quarterly to QA Committee.	11/6/14



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S 000	Initial Comments  Surveyor: 32333 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 9/15/14 through 9/17/14. Bennett County Hospital and Nursing Home was found not in compliance with the following requirements: S206, S289, and S294.	S 000		
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.  ...Additional personnel education shall be based on facility identified needs.	S 206	<p><i>Addendums noted with an asterisk per 10/17/14 telephone to facility administrator. JAS/DOH/MF</i></p> <p>S206 Employees F,H,I,J, and K will receive training on the following topics:</p> <ul style="list-style-type: none"> <li>• Proper use of restraints</li> <li>• Dining assistance, nutritional risks, and hydration needs of residents</li> <li>• Care of residents with unique needs</li> </ul> <p>This training will be provided by the DON and documented with date provided and a copy will then be added to each employee's file.</p> <p>Facility will institute policy whereby all new NH employees will receive education in the 10 required areas as stated within the first two weeks of hire. Education method may include verbal discussion, printed handouts, and or video/computer based healthcare education programs. All 10 required areas will be added to the facility orientation checklist. It will be the responsibility of the Department Manager hiring to ensure the employee receives the appropriate education and</p>	11/6/14

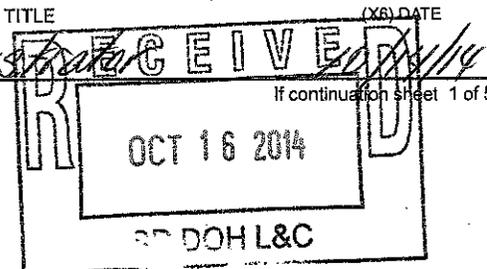
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Ethel Martin*

TITLE

*Administrator*

(X6) DATE



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S 206	<p>Continued From page 1</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32573 Based on record review and interview, the provider failed to ensure all mandatory education for five of five sampled staff members (F, H, I, J, and K) had been completed and documented. Findings include:</p> <p>1. Record review on 9/16/14 of employee files of those hired between March 2014 and September 2014 revealed staff F, H, I, J, and K had not received mandatory training on the following topics when hired: *Proper use of restraints. *Dining assistance, nutritional risks, and hydration needs of residents. *Care of residents with unique needs.</p> <p>Interview on 9/16/14 at 1:10 p.m. with the director of nursing (DON) revealed different training had been given depending on which area of the nursing home the employee worked in. Restraints had been a yearly training but should have been given to nursing staff having been hired. Dining assistance, nutritional risks, and hydration needs should have been yearly and with orientation for all staff. Residents with unique needs would have been covered on an "as needed" basis depending on the resident population. Alzheimer's trainings were given throughout the year.</p> <p>Interview on 9/17/14 at 9:00 a.m. with the DON confirmed records for the above staffs' training on orientation had not been found for all five sampled employees.</p>	S 206	<p>to sign the orientation checklist with the date received, then deliver completed checklist to Human Resources Manager for addition to the employee's file. HR Manager will add this indicator to the Employee File checklist and will check all new employee files monthly to ensure completion and report any discrepancies to the appropriate Department Manager for completion. HR Manager will report findings monthly to QA Committee.</p>	
S 289	44:04:07:02.03 FOOD SUBSTITUTIONS	S 289		

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S 289	<p>Continued From page 2</p> <p>Reasonable substitutions of equal nutritional value shall be offered to...residents who refuse or are unable to eat the food served.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32333 Based on record review and interview, the provider failed to ensure food substitutions had been approved by the dietician before they had been served to residents that had requested a food alternative or residents requiring an altered diet. Findings include:</p> <p>1. Review of the provider's September 2014 American Diabetic Association (ADA) , renal, liberalized, pureed, and finger foods diets revealed they had not been signed as approved by the registered dietician (RD).</p> <p>Interview on 9/17/14 at 9:10 a.m. with the administrator revealed she would have expected the above listed diets to have been signed by the RD to ensure equal nutritional value had been provided to the residents requiring those diets. She confirmed there had been no alternative menu for residents that requested something different than what had been on the menu. She agreed without an alternative menu for those residents they would not be able to ensure equal nutritional value had been maintained.</p>	S 289	<p>S289 Food substitution lists will be developed by the RD and the DM. Lists will be reviewed, signed, and dated by RD annually. Copies of the substitution list will be made readily available in the cooks' area for easy referencing. It will be the responsibility of the DM to check compliance with this indicator monthly and report findings to QA Committee quarterly.</p>	11/6/14
S 294	<p>44:04:07:04 Written Menus</p> <p>Any regular and therapeutic menu, including therapeutic diet menu extensions for all diets</p>	S 294		

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S 294	<p>Continued From page 3</p> <p>served in the facility, must be written, prepared, and served as prescribed by each...residents's physician. Each menu must be written at least one week in advance. Each planned menu must be approved, signed, and dated by the dietitian for all facilities. Any menu changes from month to month must be reviewed by the dietitian and each menu must be reviewed and approved by the dietitian at least annually where applicable. Each menu as served must meet the nutritional needs of the...residents in accordance with the physician's orders and the Recommended Dietary Allowances of the National Research Council.. Tenth Edition, 1989. Records of menus as served must be filed and retained for 30 days.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32333 Based on record review and interview, the provider failed to ensure: *Menus and extensions (specialized diets) had been signed by the registered dietician (RD) annually. *There had been an alternative menu for residents who had not wanted to eat the regular menu. Findings include:</p> <p>1. Review of the current menus that had been dated August 2013 and September 2013 revealed they had the registered dietician's signature, but had not been dated.</p> <p>Review of the provider's September 2014 American Diabetic Association (ADA), renal, liberalized, pureed, and finger foods diets</p>	S 294	<p>S294 RD reviewed regular and therapeutic menus and signed, dated signatures on 10/03/2014. DM will check all menus and extensions quarterly to ensure annual signature with date by the RD. DM will report findings quarterly to QA.</p> <p>* Alternative menus will be reviewed, signed and dated by the Registered Dietician by 11/6/14. JHSDDOHMF</p>	11/6/14

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S 294	Continued From page 4  revealed they had not been signed as approved by the RD.  Interview on 9/17/14 at 9:10 a.m. with the administrator revealed she would have expected the above listed diets to have been signed by the RD to ensure equal nutritional value had been provided to the residents requiring those diets. She confirmed there had been no alternative menu for residents that requested something different than what had been on the menu. She agreed without an alternative menu for those residents they would not be able to ensure equal nutritional value had been maintained. She would have expected all menus to have been signed and dated to ensure they were signed annually.	S 294		